

ABILITY MENTORING DAY

STUDENT APPLICATION



PERSONAL INFORMATION:

Last Name: _____

First Name: _____

Today's Date: _____ Male _____ Female _____ Date of Birth _____

Address: _____

Phone/TTY: _____ E-mail: _____

EDUCATIONAL INFORMATION:

Current Grade Level: _____

What are your intended Post-School Outcomes? (check all that apply and describe)

Post-secondary Education/Training

Please describe: _____

Employment

Please describe: _____

Community Living

Please describe: _____

EMPLOYMENT EXPERIENCE (or other volunteer activities, hobbies, etc.):

PLEASE
RETURN TO
TEACHER

BLAST
Intermediate
Unit 17

Northern Tioga
School District

Partners in
Progress

Southern Tioga
School District

Tioga County
Department of
Human Services

Wellsboro Area
School District



ABILITY MENTORING DAY

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CAREER INTERESTS:

During the Tioga County Ability Mentoring Day, you will be matched with a Workplace Mentor at a job site. In order to help you benefit from this experience in planning your future career, please rate your top three choices among the following career clusters. If possible, you will be paired with a person in one of the clusters you select.

1 = 1st Choice

2 = 2nd Choice

3 = 3rd Choice

_____ Administration, accounting, and financial services

_____ Animal Care

_____ Automotive/Transportation Services

_____ Childcare services

_____ Clerical

_____ Computer science and data processing

_____ Copy Center services

_____ Education

_____ Floral Design

_____ Food services

_____ Health services

_____ Human resources

_____ Legal services (Courtroom)/Criminal Justice

_____ Mailroom services

_____ Maintenance/HVAC services

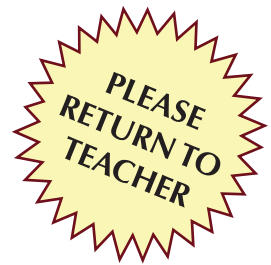
_____ Management

_____ Retail Sales

_____ Shipping and receiving services

_____ Social and employment services

_____ Other: Please explain (list): _____



REASONABLE ACCOMMODATIONS:

If you require accommodations to participate in Tioga County Ability Awareness Day as required by the Americans with Disabilities Act, please complete this section (check all that apply):

Sign Language Interpreter Tactile Interpreter Braille Large Print Disk

Wheelchair Access Other (please specify): _____

Special dietary request: Vegetarian Other (please specify): _____

**THIS SECTION SHOULD BE COMPLETED BY SCHOOL PERSONNEL
(i.e. teacher, transition coordinator, agency staff)**

SCHOOL/PROFESSIONAL RECOMMENDATION

Name/Title: _____

Local Education Agency: _____ IU _____

Phone/TTY: _____ E-mail: _____

Address: _____

By signing below, I verify my review of the completed student application packet and believe that he/she could benefit by participating in the Tioga County Ability Mentoring Day. Therefore, I endorse this student's application. If necessary, please provide any comments in the box below that may assist the Disability Awareness Network in arranging the best possible experience for this student.

Signature / Title

Date

comments

Please return the complete Tioga County Ability Mentoring Day student application packet prior to September 25, 2009 to your teacher. The application packet includes the following:

- STUDENT APPLICATION form
- PARENT/GUARDIAN CONSENT form
- MEDICAL INFORMATION form

