Assistive Technology and Equipment Request Form

Please fill out this form in block letters. This document is designed to be printed and filled out manually or digitally before printing.

1. Applicant Information

Full Name:

Date of Birth (DD/MM/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

2. Primary Disability and Functional Limitations

Primary Diagnosis:

Describe Functional Limitations (e.g., mobility, communication, vision):

3. Assistive Technology / Equipment Requested

Item 1 - Name/Description:

Item 1 - Model/Part Number (if known):

Item 1 - Estimated Cost:

Item 2 - Name/Description:

Item 2 - Model/Part Number (if known):

Item 2 - Estimated Cost:

Justification for Requested Equipment:

4. Assessor / Recommender Information

Assessor Name:

Professional Title/Role:

Organization/Clinic:

Contact Phone:

Contact Email:

5. Delivery and Installation Details

Delivery Contact Name:

Delivery Address (if different from applicant):

Special Delivery or Setup Instructions: _____

6. Signatures (For Printed Sign-off)

Applicant/Guardian Signature: _____

Date (DD/MM/YYYY): _____

Assessor Signature: _____

Date (DD/MM/YYYY): _____