

City College of San Francisco
Disabled Student Programs & Services
REAL -TIME CAPTIONING REQUEST FORM
Semester _____ Year _____

NAME: _____
Last First Middle Initial

ID#: _____ EMAIL: _____

IMPORTANT: Please fill out all the information requested in the space provided. Please email form to **GHDIVHUY#FFVIHGX**.

A DSPS counselor will check the request. If the request is approved, DSPS will make every attempt to arrange services. Due to the shortage of qualified real-time captioners, alternate accommodations may need to be arranged. Please ahead and utilize priority registration. Requests made on short notice will be considered. It is your responsibility to check back with DSPS to make sure the request is approved. _____ (Initials)

- ⊕ To schedule an appointment with a counselor, email deafserv@ccsf.edu.
- ⊕ To receive realtime captioning services, you must register with DSPS each semester. Medical verification of hearing loss must be on file.
- ⊕ To cancel captioner request, email deafserv@ccsf.edu 48 hours would be appreciated. _____ (Initials)

CLASS/EVENT (appointment, field trip, etc.)	DAYS/DATE	TIME	INSTRUCTOR	CAMPUS/ROOM
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1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Captioner(s) Requested: _____

Every attempt will be made to honor your request. We cannot promise that the captioner you request will be available.

Students must complete a separate Captioner Request Form for each class. _____ (Initials)

I give DSPS permission to inform my instructors in advance that a captioner will be providing services to a Deaf/hard of hearing student during class meetings.

Student Signature: _____ Date: _____
