

**Power Pathway's Application
2025-2026**

Personal Information

Full Name: _____
Date of Birth: _____
Gender: Male Female Non-Binary Prefer not to say
Student ID (if applicable): _____
Home Address: _____
City: _____ State: _____
Zip Code: _____
Phone Number: _____
Email Address: _____

Educational Information

Current School/Institution: _____
Year of Study/Grade Level: _____
Certificate or Diploma (if applicable): _____
Expected Graduation Date: _____

Previous Educational Accommodations (if any):

Yes No

If yes, please describe: _____

Are you currently receiving SSI or SSDI?

Yes No

Are you currently a client of Employment and Independence for People with Disabilities?

Yes No

Are you a client of any other agency?

Yes No

If yes, please describe: _____

Work and Volunteer Experience

Please list any work or volunteer experiences you have had. Include the most recent positions first.

Job/Volunteer Title: _____

Organization Name: _____

Location (City, State): _____

Start Date (MM/YYYY): _____ End Date (MM/YYYY): _____

Type of Position:

Paid Work Volunteer Work

Supervisor's Name (optional): _____

Supervisor's Contact Information (optional): _____

Responsibilities and Tasks:

(Briefly describe your primary duties in this role.)

Section 3: Medical and Disability Information

Primary Disability or Medical Condition (Check all that apply):

- Physical Disability
- Learning Disability (e.g., Dyslexia, Dysgraphia)
- Autism Spectrum Disorder
- Intellectual Disability
- Hearing Impairment
- Visual Impairment
- Speech/Language Impairment
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Emotional/Behavioral Disorder
- Chronic Illness (e.g., epilepsy, diabetes)
- Psychological Disorder (e.g., anxiety, depression)
- Other (Please specify): _____

Date of Diagnosis (if known): _____

Describe how this condition impacts your ability to learn or participate in educational activities:
(Please provide detailed information on how your condition affects your learning.)

Is applicant their own guardian?

Yes No

If no, who holds guardianship? _____

Section 4: Medical Information

Name of Healthcare Provider (e.g., physician, psychologist, etc.): _____

Phone Number of Healthcare Provider: _____

Do you take any prescribed medications related to your condition?

Yes No

If yes, please list the medication(s): _____

Are there any medical treatments or procedures that we should be aware of (e.g., insulin administration, therapy sessions)?

Yes No

If yes, please describe: _____

Do you have any medical emergencies we should be aware of (e.g., seizures, allergies)?

Yes No

If yes, please describe: _____

Section 5: Accommodations

Please check the accommodations you are requesting:

- Extended time for exams and assignments
- Note-taking assistance
- Alternative formats for reading materials (e.g., Braille, large print, audio)
- Assistive technology (e.g., screen readers, text-to-speech software)
- Accessible classrooms and buildings
- Sign language interpreter or closed-captioning
- Specialized seating or desk arrangements
- Extended deadlines or flexibility in attendance
- Other (please specify): _____

Please explain why you are requesting these accommodations and how they will support your educational success: (All accommodations will need to go through Disability Access Services).

Personal Statement

Please explain why you would like to be in the Power Pathways program.

Emergency Contact Information

Name of Emergency Contact: _____

Relationship to Student: _____

Phone Number: _____

Alternative Phone Number: _____

Email Address: _____

Home Address: _____

Supporting Documentation

Please attach the following required documents (check all that apply):

- Medical Documentation (e.g., letter from a physician, diagnosis confirmation and/or Psychological)
- Individualized Education Program (IEP) or 504 Plan (if applicable)
- High School Transcript
- Adaptive Behavior Checklist (Filled out by someone not related to student)
- Disability Forms (FERPA and Student Consent to Release Services)
- Guardianship papers if applicant is not own guardian

I understand that the information provided in this application is necessary for the administration of the Power Pathways College Program. I certify that the information provided is accurate and complete. The application will not be accepted if the required documents are not submitted.

I also understand that I may be required to provide further medical documentation to verify my condition and accommodation needs.

Signature of Applicant: _____

Date: _____

Parent/Guardian Signature (if under 18) and if applicant is not own guardian: _____ **Date:**

Please use the additional space below if needed.

Consent to Release Student Information

Per Compliance with "The Family Educational Rights and Privacy Act of 1974" (FERPA)

I, _____, hereby permit Guilford Technical Community College to release the following information from my educational records (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Academic Standing | <input type="checkbox"/> Payment Information/History | <input type="checkbox"/> All Records |
| <input type="checkbox"/> Class Schedule for Current Term | <input type="checkbox"/> Registration History | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cumulative Credit Hours | <input type="checkbox"/> Transcript/Grades | _____ |
| <input type="checkbox"/> Financial Aid Information | <input type="checkbox"/> Veterans' Information | |

FERPA requires that you state the purpose of the disclosure(s): _____.

The above information may be released in person or in writing to the following individual(s)/parties, **once s/he has confirmed my social security number, date of birth, and/or other specific identifying information that may be requested.** (Additional names: attach additional pages)

 Printed Name

 Printed Name

I understand that the above information is considered private information under the Federal FERPA guidelines. By completing and signing this form, I realize that this information will be released **only** to the party(ies) indicated. Information cannot be requested or be released via the internet. This release does not cover Counseling Services records. I understand that I have the right not to consent to the release of my educational records; that I have the right to receive a copy of such records upon request. **This release does NOT authorize others to drop classes on my behalf.**

This form must be submitted in person, by mail, or by FAX, with picture identification to Enrollment Services, located in the Medlin Campus Center, 2nd level, Jamestown Campus. *This agreement will remain in effect until revoked in writing by me, the student.

 Student Name (printed) / Birth mo./day/yr.

 Student GTCC Identification Number

 Student Signature

 Date

 Student E-mail Address

 Student Phone Number

***I request for this agreement to be cancelled.** _____
Student Signature Date

Office use only: Copy of student's state ID (such as Driver's License) must be attached to this form.
 Notes placed in ASUM/Comments: (Entry **required in this format: crf mo/day/yr your initials. To whom; list items checked for release.**)

by _____ (Staff signature required) _____ Date