

**ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
BUSINESS ENTERPRISE PROGRAM FOR MINORITIES,
FEMALES, AND PERSONS WITH DISABILITIES**

REGISTRATION FORM FOR CONTRACTUAL HIRES

Please print clearly.

1. APPLICANT'S NAME _____

2. ADDRESS _____

3. CITY _____ STATE _____ ZIP _____

4. AREA CODE AND TELEPHONE _____

5. SOCIAL SECURITY NUMBER _____

6. AGENCY OR UNIVERSITY CONTRACTING WITH EASTERN ILLINOIS UNIVERSITY

7. *MALE* *FEMALE*

8. *CHECK ALL THAT APPLY.*

AFRICAN AMERICAN

ALASKAN NATIVE

ASIAN AMERICAN

HISPANIC

CAUCASIAN

NATIVE AMERICAN

PERSON WITH A DISABILITY

(MUST HAVE PBE ADDENDUM ATTACHED) (NOT REQUIRED OF STUDENTS)

SIGNATURE

9/26/00

PBE APPLICATION STATEMENT

Effective January 1, 1992, Public Act 87-701 allows for persons with disabilities to participate in the Business Enterprise Program for Minorities, Females and Persons with Disabilities.

Persons With A Disability shall mean a person who is a citizen or lawful permanent resident of the United States and who has a medically diagnosed, severe physical or mental disability that results from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculoskeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia and other spinal cord conditions, sickle cell anemia, specific learning disabilities, or end stage renal failure disease and substantially limits at least one of the major life activities such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance or work skills in terms of employability; or any other disability or combination of disabilities which is determined by an evaluation of rehabilitation potential to cause a comparable degree of substantial functional limitation similar to the specific list of disabilities listed above.

If you qualify as a person with a disability under the above definition, please provide the following information:

() Contractual hire has been or currently is a Department of Rehabilitation Services client in the Vocational Rehabilitation Program.

If checked, do not proceed.

If not checked, the following documentation must be obtained from a licensed medical physician which addresses the definition of (Disability).

NAME

DISABILITY

FUNCTIONAL LIMITATION

CHECK ALL APPROPRIATE

- () MOBILITY
- () COMMUNICATION
- () SELF-CARE
- () SELF-DIRECTION
- () INTERPERSONAL SKILLS
- () WORK TOLERANCE
- () WORK SKILLS
- () OTHER

SIGNATURE OF CERTIFYING PHYSICIAN

DATE

PHYSICIAN'S LICENSE NUMBER

DATE

This form is being requested by the Business Enterprise Program for Minorities, Females, and Persons with Disabilities, Illinois Department of Central Management Services, to fulfill compliance report requirements for the Business Enterprise for Minorities, Females and Persons with Disabilities Act.