



# FERRIS STATE UNIVERSITY

## Educational & Career Counseling Center and Disabilities Services

### Student Request for Services Form

#### Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

For mailing purposes circle the preferred mailing address

Local Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Cell No.: \_\_\_\_\_ Fax No. : \_\_\_\_\_

Parents/Guardian/Spouse Name(s): \_\_\_\_\_

#### Academic Information

**Current Student:**  Freshman  Sophomore  Junior  Senior  Grad/Professional

Campus Wide ID Number: \_\_\_\_\_ Semester Applying for: \_\_\_\_\_

Degree Program:  Allied Health  Arts & Science  Business  Education  Technology  University

Major: \_\_\_\_\_ Perkins Program:  Yes  No

**Prospective Student:**

Admitted As Student:  Yes  No  Incoming Freshman  Transfer Student

Degree Program:  Allied Health  Arts & Science  Business  Education  Technology  University

Major: \_\_\_\_\_ Anticipated Enrollment Date: \_\_\_\_\_  
Semester (Spring, Fall, Summer & Year)

## Disability Information

Check all that apply:

**Physical/Sensory/Medical Impairment:**

- |   |   |
|---|---|
| <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)/<br>Attention Deficit Disorder (ADD) |
| <input type="checkbox"/> Mobility Impairment      | <input type="checkbox"/> Autism Spectrum/Pervasive Development Disorder                                       |
| <input type="checkbox"/> Neurological Condition   | <input type="checkbox"/> Traumatic Brain Injury/ Acquired Brain Impairment                                    |
| <input type="checkbox"/> Visual Disability        | <input type="checkbox"/> Psychiatric/Psychological Condition  |
| <input type="checkbox"/> Deaf/Hard of Hearing     | <input type="checkbox"/> Specific Learning Disability   |
| <input type="checkbox"/> Speech/Language          | <input type="checkbox"/> Other: _____   |

Please describe your disability, including date of onset and diagnosis:

Current Medications: \_\_\_\_\_

Are you registered with the Michigan Rehabilitation Services?  Yes  No Branch: \_\_\_\_\_  
(City)

Counselor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Accommodations

What accommodations have you used in the past? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the academic accommodations you are requesting: (e.g., test accommodations, e-text, notetakers)

\_\_\_\_\_  
\_\_\_\_\_

If applicable, list the housing accommodations you are requesting for living on campus: (e.g., wheelchair accessible, visual alarms)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send Information To: Ferris State University

**Disabilities Services**

901 S State ST., STR 313

Big Rapids, MI 49307

Phone: 231-591-3057 Fax: 231-591-3939