



FERRIS STATE UNIVERSITY
Educational Counseling & Disabilities Services
(ECDS) Arts and Sciences Commons 1017
Big Rapids, MI 49307
ecds@ferris.edu
(231) 591-3057 (Telephone)
(231) 591-3939 (Fax)

Student Request for Services

Personal Information

Name: _____ Date: _____

FOR MAILING PURPOSES CHECK THE PREFERRED MAILING ADDRESS.

___ Local Address: _____ City: _____ State: _____ Zip Code: _____

___ Permanent Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone No.: _____ E-Mail: _____

Cell No. & Name of Cell Phone Service Provider: _____ Fax No. : _____

Parents/Guardian/Spouse Name(s): _____

Have you used our services in the past? If yes, year: _____

Academic Information

STUDENT STATUS:

Current Student

Prospective Student

Freshman

Sophomore

Junior

Senior

Grad/Professional

Student ID Number: _____ Semester Applying For Services: _____

If Not Enrolled - Anticipated Enrollment Date: _____ Semester (Fall, Spring, Summer & Year)

Academic College/Unit

Arts & Sciences

Michigan College of Optometry

Business

Pharmacy

Education and Human Services

Professional and Technological Studies

Engineering Technology

Retention and Student Success

Health Professions

Major: _____

Disability Information

Check all that apply:

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

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

Current Medications: _____

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

M.R.S. 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, note-takers)

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

