

**HOLY FAMILY UNIVERSITY
COUNSELING CENTER & DISABILITY SERVICES**

STUDENT: Please fill out the following information and return this form to Holy Family University, Counseling Center & Disability Services, 9801 Frankford Avenue, CC222, Philadelphia, PA 19114-2094:

Name: _____ DOB: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Address (on Campus) : _____

Phone: (_____) _____ Cell Phone: (_____) _____

Social Security #: ____--____--_____ Enrolled in a degree program? Y___ N___

Academic Status: Not yet registered Fresh. Soph. Jr. Sr. Grad. Enrich. Certif.

Major: _____ Division: _____ Advisor: _____
(if known) (if known)

Transfer Student? Y___ N___ If yes, names & dates of college(s) and/or university(ies):

Please check all that apply:

Part-time student _____ Out-of-state _____ Summer study _____
Full-time student _____ In-state _____ Certification _____

Were you referred to the Disability Office? Yes ___ No ___ By whom? _____

Have you previously received accommodations at Holy Family University? Yes ___ No ___
If so, when? (Please circle): Spring Fall Summer Year: _____

REQUIRED: Please describe the accommodations/academic adjustments you are requesting
(continue on back of page if needed):

Professionals from whom we will be receiving documentation: _____
