This form must be completed by the student.

KEAN

## OFFICE OF ACCESSIBILITY SERVICES

88 Daxue Rd., Ouhai, Wenzhou TEL: (+86) 577-55870153 EMAIL: xiazhenzhen@wku.edu.cn

## STUDENT INTAKE APPLICATION

Name: _____ Date: _____

Date of Birth: _____ WKU-ID/_____

Home Address: _____

Residential Hall: _____ RHD:_____

Major and Grade Level:_____ Cell phone: _____

WKU Email: _____@wku.edu.cn Personal Email: _____@_____

Expected Graduation Date: _____ Who referred you to OAS?_____

What is your diagnosed disability?

_____

Student: Please describe how your disability impacts your performance as a student:

_____

_____

List any medications you are currently taking along with dosage, frequency, and who prescribed them:

_____

_____

# This form must be completed by the student.

Describe any long-term medical problems, illnesses or injuries you have had:

_____

_____

Describe any hospitalizations you have had in the last five years:

_____

_____

How would you rate your general health:

_____ Excellent _____Good _____Fair _____Poor

Have you ever received any assistance from an outside agency (such as DVR or CBVI) for academic, career, or personal counseling or support? _____

Name of agency: _____ when: _____

For what reason: _____

Are you now in counseling or therapy? _____ When did you start with your current therapist? _____

Name of therapist: _____ Phone Number: _____

Have you had any previous therapy or counseling? _____ When? _____

When did you graduate from high school? _____ OR Receive GED? _____

Name of high school: _____

Have you attended another college or university? _____ When? _____

Where? _____ Degree or credit hours achieved: _____

List any accommodations/adaptive technology you used in high school or college:

_____

_____

This form must be completed by the student.

**Note: Should the student's condition change (for better or worse), the student must provide updated documentation in order for the accommodations to be adjusted accordingly**.

Please read the statement below and sign your signature below, if you agree with the statement.

**I promise that the information and medical documents that I provide to the Office of Accessibility Services are true. If any of information or documents is found to be false/spurious, I am aware that I will receive severe sanction from the University and all my accommodations will be terminated.**

I agree with this statement by signing below:

**Student's signature_____**

**(Print)Student's Name_____Date_____**