Department of Special Education and Communicative Disorders
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COMMUNICATIVE DISORDERS CLINIC
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Clinic Director: Patti Solomon-Rice, Ph.D., CCC-SLP
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APPLICATION FOR SPEECH, LANGUAGE, AND/OR HEARING SERVICES

Date: _____

Name of Applicant: _____ Sex: _____ Birth Date: _____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Email: _____

Address: _____ City: _____ Zip: _____

Person completing application/relationship to client: _____

Is Applicant bi-lingual? Yes ____ No ____ Which language? _____
Which language would be considered the primary language? _____
Which languages are spoken at home? _____
What is the native language of parent/guardian #1? _____
What is the native language of parent/guardian #2? _____
Would it be helpful to have an interpreter if an evaluation is required? _____
We will make every attempt to provide interpreter services if possible when requested.
Are you able to bring an interpreter? Yes _____ No _____

IF CHILD:
Parent/Guardians' Name/s: _____

Address and phone information (only if different from above)
Phone: _____

Email: _____

Address: _____ City: _____ Zip: _____

IF ADULT:

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____

What is the main concern about the applicant at this time (e.g. hearing, speech, language, medical, educational, social)? Please describe the concern in DETAIL:

_____

_____

_____

_____

Record of examinations and treatment for speech, language, hearing or other special concerns:

Name, school, or clinic	Address	Inclusive Dates of Service