



CALIFORNIA STATE UNIVERSITY, LONG BEACH
SPEECH AND LANGUAGE CLINIC
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LONG BEACH, CA 90840
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REENROLLMENT APPLICATION

(All information given on this questionnaire will be considered confidential.)

Name of Applicant _____ Date of Application _____
Sex _____ Date of Birth _____ Age _____
Address _____ City _____ Zip _____
Phone _____ Email _____
Contact Person _____ Relationship to Applicant _____
Mobile Phone Number _____ Home Phone Number _____
Email Address _____
What language(s) do you speak? _____
Communication Concern: _____

CSULB ENROLLMENT HISTORY

Last Semester of Enrollment: Fall Spring Year:

First Semester Enrolled (if known): _____

Total Number of Semesters Enrolled (if known): _____

THERAPY

List names of other settings where you are currently receiving therapy or attending support groups: