

OFFICE OF DISABILITY SERVICES
Eastern Illinois University/Student Service Feedback Survey

DATE: _____

SEMESTER: _____

Reason for meeting:

- _____ Informational
- _____ Questions/Concerns
- _____ Seeking Accommodations

Name: (optional) _____ Phone: (optional) _____

Please rate the quality of services you received with our office:

- | | |
|--------------------|-----------------------|
| 4 = Strongly Agree | 1 = Strongly Disagree |
| 3 = Agree | NA = Not Applicable |
| 2 = Disagree | |

My experience with the Office of Disability Services has been positive	4	3	2	1	NA
I received courteous service	4	3	2	1	NA
My requests were addressed in a timely manner	4	3	2	1	NA
I received useful information	4	3	2	1	NA
I was given the opportunity to express my concerns fully	4	3	2	1	NA

Comments: _____

Please return to EIU Disability Services, 600 Lincoln Avenue, Room 2006, 9th Street Hall, Charleston IL 61920