



**PROGRAM REFERRAL
Oregon State University SSS**

Date: ___ / ___ / ___

Referring Advisor Name: _____ TRiO Program/Location: _____

Phone: _____ Email: _____

Student Name: _____ OSU Student ID: _____

Email: _____ Phone#: _____

First term of planned OSU enrollment: _____ High School: _____ Year graduated: _____

Is the student transferring: yes no # of transfer credits: _____ Institution: _____

Insights from use of your program:

Likelihood of continued TRiO services needed (circle one)? Possible Likely Definite

Use of TRiO services at your school (circle one)? Light Medium Heavy

Exited from your SSS? Yes [Date exited: _____] No

Community College Graduate? Yes No

Pell Eligible? Yes No

Other information that would be useful in facilitating good OSU connections:

**TRiO Student Support Services
337 Waldo Hall, OSU, Corvallis, Oregon 97331-6405
FAX: 541-731-3998
<http://oregonstate.edu/dept/sss>**