

4. What are your educational goals? (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Prepare for a new career (new skills) | <input type="checkbox"/> Bachelor's degree after AA degree |
| <input type="checkbox"/> Advance current job/career(update skills) | <input type="checkbox"/> Bachelor's degree without AA degree |
| <input type="checkbox"/> Vocational degree without transfer | <input type="checkbox"/> Maintain certificate or license |
| <input type="checkbox"/> AA degree without transfer | <input type="checkbox"/> Improve basic skills |
| <input type="checkbox"/> Vocational certificate without transfer | <input type="checkbox"/> Undecided |

*5. Check the age when your primary disability occurred:

- | | | |
|--|---|--|
| <input type="checkbox"/> At birth | <input type="checkbox"/> 6 to 18 years | <input type="checkbox"/> 38 to 55 years |
| <input type="checkbox"/> 5 years & under | <input type="checkbox"/> 19 to 37 years | <input type="checkbox"/> 56 years and over |

*6. Are you a consumer with the Department of Rehabilitation? yes no

Counselor's Name _____ Phone _____

7. Are you receiving services from any other campus or community program related to a disability?

If so, please describe _____

8. Have you ever received services for students with disabilities from any other college prior to attending LACC? yes no

9. Are you receiving Financial Aid? yes no

* I certify that the foregoing statements on my application for Office of Special Services are complete and accurate.

(Signature)

(Date)

EMERGENCY INFORMATION

*1. List name of person to be notified in case of emergency:

Name _____

Relationship _____ Phone _____

Address _____ City _____ ZIP _____

Statement of Student Responsibility

Los Angeles City College provides services and access for eligible students with documented disabilities who intend to pursue coursework at LACC. Through appropriate and reasonable accommodations, students are provided the opportunity to participate fully in all aspects of LACC programs.

Completion of this form is required before services are provided by OSS.

Student Responsibilities:

1. I will provide OSS with any information deemed necessary by OSS to verify my disability (ies); i.e., medical doctor or rehabilitation counselor complete name, address and phone number.
2. I will meet with an academic counselor to complete a Student Educational Plan and I agree to meet annually to update my Student Educational Plan.
3. I will make measurable progress towards the goals established in the Student Educational Plan and meet academic standards established by the college.
4. I will utilize the OSS services in a responsible manner according to the rights and responsibilities of OSS.
5. I will comply with the Student Code of Conduct adopted by the Los Angeles Community College District.

I understand that I must fulfill the Program and Student Responsibilities in the OSS Program. I have received a copy of the policy on suspension of OSS services, and I understand the consequences of failing to comply with the rules for responsible use of OSS services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application I affirm that I understand and agree with the OSS Program and student responsibilities and I will abide by them.

Student Signature: _____

Date: _____

Section II. Confidentiality

Student Release of Information

I, _____, grant permission for the Office of Special Services to release and exchange information consistent with the Federal Family Education Rights and Privacy Act of 1974, or other laws and regulations with the appropriate college staff through the Los Angeles Community College District. I am aware that all information will be used solely for the purpose of my educational planning and the implementation of services related to my disability. I am also aware that all information will be kept confidential. This release shall remain in effect until I notify OSS in writing that it is no longer valid.

I authorize the release of information that may include one or more of the following records:

- Verification of Eligibility
- Functional Limitation(s)
- Academic Accommodation(s)
- Educational Records, Including Progress Reports, Assessment Scores.
- Other: _____

Student Signature

(Date)

****Office Use Only****

Application processed by: _____

- Summer/Fall
 - Winter/Spring
- Year: _____

Disability and services:

- (*) Not Eligible
- (1) Primary, full services
- (3) Secondary, full service

___ **Mobility** ___ **Visual** ___ **Other** ___ **Hearing** ___ **Speech**
___ **L. D.** ___ **A. B. I.** ___ **D. D. L.** ___ **Psychological** ___ **Substance**

OSS Counselor/Specialist Signature _____ Date _____

OSS Counselor/Specialist Signature _____ Date _____

OSS Counselor/Specialist Signature _____ Date _____