



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 client of the Department of Rehabilitation?  yes  no

Rehabilitation Counselor's Name \_\_\_\_\_ Phone \_\_\_\_\_

7. Are you receiving disability services from any other agency, campus, or community program?

If so, please describe \_\_\_\_\_

8. Have you ever received services for students with disabilities from any other college or university prior to attending LACC?  yes  no If "yes" list: \_\_\_\_\_.

9. Are you receiving Financial Aid?  yes  no

10. Are you a US Veteran?  yes  no

11. Are you a Foster Youth?  yes  no

### **EMERGENCY INFORMATION**

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

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

2. List any medication(s) that you are taking at the present time that should be recorded in case of emergency.

Name of Medication \_\_\_\_\_

Name of Medication \_\_\_\_\_

## Statement of Student Responsibilities

The Office of Special Services provides programs and services for students at LACC that have a verifiable disability AND disability related educational functional limitations. Through appropriate and reasonable accommodations, students are provided the opportunity to participate in LACC instructional programs.

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

Student Responsibilities:

1. I will update my OSS application each semester that I enroll in classes at LACC.
2. I will provide OSS with any information (reports, diagnosis, etc.) deemed necessary by OSS to verify my disability (ies); i.e., medical, psychological, and/or educational signed by an appropriately licensed professional.
3. I will meet with an academic counselor/specialist to complete a Student Educational Plan/Contract and I agree to meet each semester to update my Student Educational Plan/Contract and Academic Accommodations.
4. I will make measurable progress towards the goals established in my Student Educational Plan and meet academic standards established by the college.
5. I will utilize all OSS programs and services in a responsible manner including notification forty-eight (48) hours in advance for OSS service cancellations, appointment changes, or requests for information related to my OSS student file.
6. I will comply with the Student Code of Conduct adopted by the Los Angeles Community College District.

**\* I certify that the foregoing statements on my application for the Office of Special Services are complete and accurate. I have read, understand, and will abide by the Statement of Student Responsibilities listed above. I understand the consequences of failing to comply with the rules for responsible use of OSS services may result in suspension of services from OSS and I will be notified before any action is taken with right of appeal. By signing this application I affirm that I understand and agree to the OSS Student and Program Responsibilities.**

\_\_\_\_\_  
(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. This release shall remain in effect until I notify OSS in writing that it is no longer valid.

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

- Verification of eligibility including diagnosis.
- Functional limitation(s).
- Academic accommodation(s) and/or adjustments.
- Educational records including progress.
- Other: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Student Name \_\_\_\_\_ ID Number \_\_\_\_\_

Student Contact \_\_\_\_\_  
(Email and/or Phone Number)

**\*\*Office Use Only\*\***

**Application processed completed by:** \_\_\_\_\_

- Summer
  - Fall
  - Winter
  - Spring
- Year: \_\_\_\_\_

**Verified disability categories:**

- (1) Primary
- (2) Secondary(s)
  
- (NE) Not Eligible

\_\_\_\_\_ **Hearing** \_\_\_\_\_ **A. B. I.** \_\_\_\_\_ **L. D.** \_\_\_\_\_ **Visual** \_\_\_\_\_ **Mobility**  
\_\_\_\_\_ **D. D. L.** \_\_\_\_\_ **Speech** \_\_\_\_\_ **Psych** \_\_\_\_\_ **Other:** \_\_\_\_\_

OSS Counselor/Specialist Signature \_\_\_\_\_ Date \_\_\_\_\_

OSS Counselor/Specialist Signature \_\_\_\_\_ Date \_\_\_\_\_

OSS Counselor/Specialist Signature \_\_\_\_\_ Date \_\_\_\_\_

OSS Counselor/Specialist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Verification Notes:**