



Office of Special Needs Services

INTAKE

Coordinator Appointment Date:

Please complete this form before your scheduled date for a productive meeting.

Date: _____

BIOGRAPHICAL INFORMATION

Name: _____
(first, last, MI)

Student Number: _____ Social Security Number: _____

Email: _____ Birth date: _____

Address: _____ Apt.# _____

City, State, Zip: _____

Phone: _____ Other Phone: _____

Referred to Office of Special Needs Services (OSNS) by _____

Graduated from: _____ Year: _____

College curriculum you are interested in: _____

DISABILITY INFORMATION

Please list Disability (ies):

Date of onset and/or diagnosis

_____/_____/_____

_____/_____/_____

_____/_____/_____

_____/_____/_____

Documentation from a qualified professional is required prior to receiving services.

Primary Health Professional : _____

Address : _____ Phone: _____

Secondary Health Professional: _____

Address: _____ Phone: _____

Please continue on back

Current Medications: _____

Medical Restrictions: _____

Are you registered with BVR or another sponsoring agency? Yes No

If yes, who is your counselor? : _____

ACCOMMODATIONS

Please list any academic accommodations or support services you have received in the past.

Please list any academic accommodations or support services you would like to request at Lorain County Community College. _____

Please note any additional information that may assist OSNS in providing you with accommodations.

I understand information collected here is for assistance in determining disability accommodations for my educational endeavors and will be kept confidential in OSNS. Information listed here is true and complete to the best of my knowledge.

Signature: _____

Date: _____

For Office Use Only
New File Created ____
File Incomplete file ____
Entered in CMDS file ____
Completed by ____
Revised TS 12/2004