LSSU Office of Accessibility Services
Attn: Megan Norman
650 W. Easterday Avenue
Sault Ste. Marie, MI 49783
accessibility@lssu.edu
Phone: 906-635-2355
Fax: 906-635-2193

LSSU Accessibility Services Registration Form

Step #1: Please complete and submit this Registration Form.

Step #2: Please submit the Medical Documentation Form along with any relevant supporting medical test results.

OR

Please submit a typed and signed letter on an official letterhead completed by a medical practitioner which includes the diagnosis, relevant test results, functional limitations/behavioral manifestations and recommended accomodations. The letter must include name printed, profession, license number, contact information and signature of the provider listed. The letter must be addressed to the LSSU Office of Accessibility Services.

Student Contact Information: (Please Print)

Student Identification (A#): ___________________________ Date of Birth: __________________

First Name: _______________________ M.I. ____ Last Name:_____________________________

LSSU Email Address: __________________________________

What is your major? ___________________________________

Are you pursuing an Associate's Degree? If yes, please list: _________________________

Disability or Disabilities Information:

Please identify your disability or disabilities.

____

____

In your own words, please describe how your disability affects you:

____

____

____

____

Please describe the barriers you experience with regards to academics and activities of daily living.

____

____

____

____

What accommodations/services do you hope to receive?

____
____
____

What accommodations/services/assistive technology have you used in the past that was successful or unsuccessful?

____
____
____

LSSU Services/Resources:

Have you utilized any of the following LSSU Programs?

◻ LSSU Health Care Center ◻LSSU Counseling Services ◻ LSSU I-PASS Program
◻ LSSU Mentoring Program ◻ LSSU Career Services ◻ LSSU Tutoring

Are you a client of, or do you receive services from, any agencies?

◻ Michigan Rehabilitation Services (MRS)
◻ Other: ___________________________ ◻ Other: _____________________________

Referral Information:

Who referred you to the Office of Accessibility Services? ________________________

Perkins Vocational Grant Information: Please Circle.

Did you receive a Pell Grant this semester? Yes No	Are you an individual with limited English? Yes No
Are you a single parent? Yes No If yes, please answer below. What is your age? ______ Number of children? ______ Number of children under 10 years old? ___	Are you a veteran or a dependent of a veteran (child or spouse)? Currently in the military Veteran Spouse of a Veteran Child of a Veteran
Are you a displaced homemaker? Yes No Are you an individual with a disability? Yes No	Are you in a degree that is non-traditional for your gender? Yes No

Consent for Services

Please read carefully and **initial each statement below** to indicate that you authorize the Lake Superior State University Office of Accessibility Services to make arrangements for accommodations on your behalf.

Permission to Discuss and Arrange for Disability-Related Accommodations:

The LSSU Office of Accessibility Services endeavors to preserve the confidentiality of the student's disability information. Professors or other school officials may request information about the impact of a student's disability that may relate to safety needs or a student's ability to learn. **Holding safety paramount,** the Office of Accessibility Services will only share information with other school officials when appropriate and will carefully balance a student's request for confidentiality with any request for information about the student's accommodation needs.

___ I authorize the LSSU Office of Accessibility Services to discuss my disability-related needs with LSSU staff.

___ I authorize the administrative staff of the Office of Accessibility Services to exchange information as needed with the following individuals, LSSU Departments, practitioners or agencies to enable the office to provide appropriate accommodations for me.

□ LSSU Health Center □ LSSU Counseling Center

Name: ________________________ Relationship: ______________________

Name: ________________________ Relationship: ______________________

Testing Services Policies and Procedures:

___ I permit the LSSU Office of Accessibility Services to share information regarding my testing accommodations with LSSU Testing Services.

___ I agree to adhere to the Testing Services Code of Conduct.

My Rights:

___ I understand under the Federal Education Rights and Privacy Act of 1974, only authorized LSSU staff may have access to my records unless my written consent is given or otherwise provided for in legal statutes and judicial decisions.

___ I understand this authorization will expire five (5) years from today's date.

Submitting Information:
The LSSU Office of Accessibility Services will consider all relevant information submitted by the student. Submitted information will be reviewed on an individual, case-by-case basis.

Please provide signature on next page.

I certify that all information I have provided is true and accurate to the best of my knowledge. I understand that intentionally providing false or misleading information may result in my being ineligible for services and may also result in disciplinary action by Judiciary Board.

______________________________ ______________

Signature **Date**

Please Mail, Hand Deliver, Email or Fax

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For Office Use Only:

Date Received:	**How Received:**	**Diagnosis/Diagnoses Documentation Complete?**
___/___/____ First Semester Registering w/OAS: Fall: ________ Spring: ______ Summ: ______	❏ Mail ❏ Deliver ❏ Emailed ❏ Faxed	❏ Yes ❏ No If No, What Else Is Needed: ______________________________ Date/How Additional Documentation Received: ______________________________

Perkins Notes:

Responses:	**Notes:**