

# LRC Registration Form

Name: \_\_\_\_\_ MICA ID: \_\_\_\_\_

Local Address: \_\_\_\_\_  
\_\_\_\_\_

Local Phone: (     ) \_\_\_\_\_ Email Address: \_\_\_\_\_@mica.edu

Permanent Address: \_\_\_\_\_  
\_\_\_\_\_

Permanent Phone: (     ) \_\_\_\_\_

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Semester/Year entered MICA: \_\_\_\_\_

**Present Status:**

- \_\_\_\_\_ Full-time
- \_\_\_\_\_ Part-time
- \_\_\_\_\_ Visiting
- \_\_\_\_\_ Other

**Degree Status:**

- \_\_\_\_\_ Freshman
- \_\_\_\_\_ Sophomore
- \_\_\_\_\_ Junior
- \_\_\_\_\_ Senior
- \_\_\_\_\_ Graduate
- \_\_\_\_\_ Non-Degree

Major Field of Study: \_\_\_\_\_

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**Disability Classification:**

- |  |                              |
|--|------------------------------|
| _____ Attention Deficit/Hyperactivity Disorder | _____ Learning Disorder      |
| _____ Chronic Health Disorder                  | _____ Physical Disorder      |
| _____ Cognitive Disorder                       | _____ Psychological Disorder |
| _____ Communication Disorder                   | _____ Temporary Disability   |
| _____ Hearing Disorder                         | _____ Vision Disorder        |

When was your disability first diagnosed? \_\_\_\_\_

Describe the academic implications of your disability: \_\_\_\_\_

What accommodations are you requesting? \_\_\_\_\_

Are you a Vocational Rehabilitation Client? \_\_\_\_ Yes \_\_\_\_ No If yes, what state? \_\_\_\_

Please list any medications which you are taking and how they may affect your academic work: \_\_\_\_\_

Please describe any additional concerns you have: \_\_\_\_\_

**Background information:**

Gender: \_\_\_\_ Male \_\_\_\_ Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Citizen Status: \_\_\_\_ US citizen \_\_\_\_ US permanent resident \_\_\_\_ International

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**AUTHORIZATION TO DISCLOSE DISABILITY INFORMATION**

By signing below, I hereby authorize the Learning Resource Center to disclose information about my disability to MICA professors and staff directly involved in providing academic and/or support services.

Additional persons authorized to receive above information:

- \_\_\_\_ Parent(s)
- \_\_\_\_ Diagnostician
- \_\_\_\_ Mental Health Professional
- \_\_\_\_ Other

Comments: \_\_\_\_\_

I understand that I have a right to inspect my Learning Resource Center file and that this authorization is subject to revocation, in writing, at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Witness: \_\_\_\_\_