



WALLACE STATE
H A N C E V I L L E

Athletics

October 27, 2017

Dear Athletes and Parents:

Please let me take a moment to introduce myself! I am Deborah Spann, Athletic Coordinator at Wallace State –Hanceville. I am responsible for several areas concerning athletes and athletics. One of those areas is compliance with all National and State regulations. In order to comply with these many regulations, there are several forms that must be on file in my office. Enclosed are the required forms and also directions on how to apply for admission and the FAFSA. We must have a FAFSA on file for each scholarship recipient before we can award scholarship funds. Please do not have physicals performed prior to June 1, 2017.

Please feel free to contact me at 256-352-8121 or via email at deborah.spann@wallacestate.edu, if you have any questions. Please return all the required forms to me by July 1, 2018.

I look forward to meeting and working with you this coming year! Welcome to the Wallace State Family!

Go Lions!

Deborah Spann
Athletic Coordinator/Eligibility & Compliance

Name



Checklist for Student/Athletes

- Emergency Contact/Insurance Information Form and copy of Insurance Card
- Physical and History Form
- Drug Testing Consent Form
- Acknowledgement of Insurance
- NJCAA Eligibility Affidavit
- Drug Testing Results (Mailed or faxed from facility that performed the test)
- Athletic Consent to Participate

- Release of Information
- HIPPA Authorization Form (**Must have before any athletic injury claims can be processed.**)

Admissions and Financial Aid Checklist

- WSCC Application
- Official Copy of HS Transcript or GED with graduation date, type of diploma
- If transferring, official copy of all college transcripts
- FASFA completed (Scholarship will not be entered until WSCC Financial receives verification from FAFSA)
- Copy of ID to Admissions office
- Placement or ACT Scores (20 or more Math and 18 or more English)
- Selective Service for all male athletes age 18 or above



WALLACE STATE
H A N C E V I L L E

Emergency Contact and Insurance Information Form

Name _____

Date of Birth _____

Sport _____

SSN _____

Academic Year _____

Parents/Guardians Name _____

Address _____

Home Phone _____ Cell _____ Work _____

Policy Holder Name and DOB _____

Relationship to Student-Athlete _____

Address _____

Home Phone _____

Work Phone _____

Insurance Company Name _____

Insurance Company Address _____

Group # _____

I.D.# _____

Effective Date of Policy _____ Expiration Date of Policy _____

Policy Limit _____ Policy Deductible _____ Policy Co-Pay _____

Does this policy cover athletic-related injuries? _____

Parent/Guardian Signature

Date

Student/Athlete Signature

Date

This form must be completed and returned immediately to *Ms. Deborah Spann, Athletic Coordinator*. You should keep a copy of these documents for your records. Please attach a copy of your insurance card.

PO Box 2000
Hanceville, AL 35077



PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO



HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you get more tired or short of breath more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do any of your joints become painful, swollen, feel warm, or look red?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have any history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
28. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you have a history of seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
41. Do you get frequent muscle cramps when exercising?	<input type="checkbox"/>	<input type="checkbox"/>
42. Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have you had any eye injuries?	<input type="checkbox"/>	<input type="checkbox"/>
45. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
49. Are you on a special diet or do you avoid certain types of foods?	<input type="checkbox"/>	<input type="checkbox"/>
50. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
51. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY		
52. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
53. How old were you when you had your first menstrual period?	<input type="text"/>	
54. How many periods have you had in the last 12 months?	<input type="text"/>	

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____



CONSENT TO DRUG TESTING

I understand that to participate in intercollegiate athletics, I will be required to submit to mandatory drug testing. I agree to submit to specimen collection (urine or oral) for purposes of its analysis for drug use. I further agree and consent to the disclosure of the records and results relating to this analysis to be released to the Athletic Director, Athletic Coordinator, or other designated representative in order that my eligibility to participate in the athletic program can be determined.

Student Athlete's Signature _____ Date _____

Student Athlete's Name (Printed) _____

Parent/Legal Guardian Signature _____

(If athlete is a minor)



NJCAA Eligibility Affidavit

SPORT: _____ Date: _____

Fill in all applicable information on this form to assist in determining eligibility for the NJCAA.

Personal Information:

Name: _____ Birth Date: ___/___/___ ID Number: _____
(First, Middle, Last)

Student's College Address: _____
Street Address City, State, Zip Code

Phone Number(s) at College: _____ Email Address: _____

Other Information:

Parent's Home Address: _____
Street Address City, State, Zip Code

Phone Number: _____ Parents' Names: _____

Foreign Born Students:

Do you have an I-20 Form on file at this college? Yes _____ No _____

High School Information:

Name of High School(s) you have attended: _____

City, State & Country: _____

Did you graduate?: Yes* _____ No _____ High School Graduation Date (month/date/year): ___/___/___

Were you home schooled? Yes _____ No _____ Did you graduate? Yes* _____ No _____

Check here if you have earned a *GED or state department of education approved high school equivalency test
Yes _____ No _____ If yes, enter the date earned (month/date/year): ___/___/___

*** Enclose a COPY of your High School Transcript, and GED Certificate or state department of education approved high school equivalency test (if applicable).**

Additional Information:

1. Did you take any college credit classes while in high school? Yes* _____ No _____
* If yes, from what college(s)? _____
* If yes, those transcript(s) from each college must be on file at this college.

2. Have you ever signed a Letter of Intent form with any institution? Yes _____ No _____
If yes, specify the College: _____ Date (day/month/year): ___/___/___

3. Have you ever participated in a sport in a country other than the United States? Yes _____ No _____
Sport(s)? _____ Country: _____ Dates: _____
If yes, describe the situation: _____

4. Have you ever been red-shirted for a season? Yes _____ No _____
If yes, list the dates of that season, name of college, and describe the situation. _____

- 5. Have you ever participated in practices, scrimmages, and/or games for an intercollegiate team other than this college? Yes _____ No _____ *If yes, name the school, date, sport, and describe the situation.* _____

- 6. Have you ever played on a club team at a college or university? Yes _____ No _____ *If yes, name the school, sport and dates.* _____

- 7. Do you currently play on any other sport teams (i.e. USAV, city recreational leagues, indoor soccer, AAU, etc.) Yes _____ No _____. *If yes, please provide the name of team, location, and dates of participation.*

- 8. Have you ever received money beyond expenses for participating in any athletic event? Yes _____ No _____
 Did anyone on your team receive money beyond expenses for participating in any athletic event? Yes _____ No _____
If yes, describe the situation below and the NJCAA Amateurism Questionnaire should be completed and included with the eligibility file. _____

List ALL Colleges Attended Full-Time and/or Part-Time after High School
All transcripts from all previous institutions must be included.

College: _____	Dates: _____	Full-time or Part-time? (circle one)
College: _____	Dates: _____	Full-time or Part-time? (circle one)
College: _____	Dates: _____	Full-time or Part-time? (circle one)
College: _____	Dates: _____	Full-time or Part-time? (circle one)

Additional Explanations:

NOTE: If you attended college part-time or were not attending college for any period of time following high school graduation, please document your employment and military history during those times in the space below. If you were unemployed at any time, please list those dates below. The NJCAA requires that you account for any time not enrolled full-time. Please use the space below. Please record months and years when referring to dates. _____

I understand that information falsified or omitted can make me ineligible for ALL future college competition in compliance with the National Junior College Athletic Association Eligibility Rules.

Student-Athlete Signature: _____ Date: _____

Coach Signature: _____ Date: _____

**WALLACE STATE ATHLETICS
ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS**

I, _____, as parent, guardian or legal representative, attest that
(Name, please print)

_____ has , does not have , insurance coverage under
(Student/Athlete Name)

a current, in force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics.

If there is a change in coverage or expiration of coverage, I agree to notify Wallace State Athletics of this development and update the insurance information I have on file with Wallace State Athletics.

I understand that my or my parent health insurance will serve as primary insurance for all injuries and illness. Wallace State Athletic Department has a secondary policy that ONLY applies for athletically related injuries which occur during an organized and supervised workout, practice, or competition. This policy is not responsible for any non-athletic injury or illness.

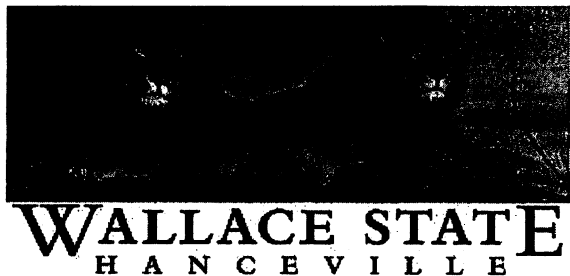
I understand that all bills and related paperwork I or my parents receive from athletically related injuries must be sent to Ms. Deborah Spann, Athletic Coordinator at Wallace State Athletics within 10 days from time of receipt.

I understand I or my parents are responsible for any and all medical expenses not covered by my insurance or the Wallace State Athletics secondary policy.

(Signature of Parent/Guardian) (Date)

(Signature of Student Athlete) (Date)

**YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT
INSURANCE CARD AND THE COMPLETED EMERGENCY CONTACT AND
INSURANCE INFORMATION FORM.**



Consent to Participate for Student/Athletes

I give my permission and understand that the athletic trainer, coaching staff, team physician, administrators, or other school officials can use their own judgment in applying first aid until medical help becomes available, or to secure medical aid and ambulance service in case parents cannot be reached. I voluntarily accept their service on my behalf and grant permission for them to perform their necessary duties as described above.

Name _____ Birth date _____ SS# _____

Phone number to reach parents during the day

Father: day phone _____

Mother: day phone _____

eve. phone _____

eve. Phone _____

cell _____

cell _____

email: _____

email: _____

Medications currently taking: _____

Known allergies: (including medications): _____

Medical conditions (diabetes, epilepsy, etc.): _____

Do you wear contact lenses/glasses? yes no

Any other medically-related condition that may affect emergency care? _____

I _____ wish to participate in _____
at Wallace State Community College, Hanceville, AL .

I am aware that the very nature of athletic participation carries with it an inherent risk of injury. I understand that the dangers and risks of participating in athletics, whether in competition or preparing to compete, include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body and general health and well being. In addition, I am aware that participation in intercollegiate athletics will involve traveling with the team, and that such traveling may expose me to the risks of a motor vehicle accident, as well as other conditions that result from traveling.

I also accept the responsibility in taking personal measures to help prevent injury to myself or other athletes by notifying the coaching staff, athletic trainer, administrators or other WSCC personnel of conditions that I am aware of that may predispose me or other athletes to an increased risk of injury resulting from athletic participation.

Having understood the risks of athletic participation and particularly the risk inherent in _____
I voluntarily assume and accept these risks as they have been explained above.

Student's signature _____

Date

Parent's signature _____

Date



Wallace State Community College—Hanceville

RELEASE OF INFORMATION FORM

In compliance with the Family Educational Rights and Privacy Act (FERPA), the policy of WSCC is to refuse to grant third party access to student records without the written consent of the individual student. Any consent given must include the specific records to be released or reviewed and the names of the individuals to whom the information may be released. If you wish to grant permission for your records to be reviewed, please complete the form below.

Student Name _____ Student # _____

I request the following records be released:

- All of my student records
- Academic Records
(including transcripts; grade appeals; academic status; advising; Admissions Office files, etc.)
- Financial Aid Records
(including all financial aid applications, awards and files; balances; fines; and Business Office files, etc.)
- Disciplinary Records
(including any disciplinary event or hearing, or other disciplinary action or response)
- Other (specify) _____

To whom may student files be released?

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Student Signature _____ Date _____

Note: There will be a service fee for producing photocopies of any records that are requested to be copied by the student or by the person to whom the student gives permission to request photocopies.

Submit Form to: Deborah Spann, Athletic Coordinator
 PO Box 2000
 Hanceville, AL 35077

Authorization to Disclose Protected Health Information

Student's Name*	Birth Date	College/University	Policy Number
Dependent's Name (if applicable)	Date of Injury or First Treatment of Sickness	Condition	

*Student or Dependent who wants to allow others to call or receive communication on their behalf.

1. I authorize medical providers to discuss, disclose and/or release information identified in Paragraph 2, below, to the following individual:

2. **Deborah Spann,**
 Name (s) of authorized person(s) **Athletic Coordinator**
 Relationship to the undersigned
PO Box 2000
 Address **Hanceville, AL 35077**
 City, State, Zip

3. I hereby authorize medical providers, Inc. to discuss, disclose, and/or release information necessary to process or respond to eligibility inquiries, coverage/benefit inquiries, claims inquiries, appeals, and Explanation of Benefits about my student health insurance coverage with respect to the Injury or Sickness identified above. I further acknowledge that the information discussed, disclosed and/or released may include individually identifiable health information about me.

4. This authorization is being made at my request.

5. In signing this Authorization, I understand and acknowledge the following (initial in the space provided):

- _____ I understand that this Authorization is voluntary and that I may refuse to sign it.
- _____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
- _____ I understand that I may revoke this Authorization at any time, by notifying WSCC Athletic in writing of my intent to revoke this Authorization, except to the extent that action has been taken in reliance on this authorization.
- _____ I understand that, unless otherwise revoked, this Authorization will expire one year after the date of this permission.
- _____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby affirm that I am the above-named student or dependent or an authorized legal representative. I have read and understand the above information.

 Date

 Signature of Student or Dependent

Admission Policy

256.352.8236

Wallace State Community College is an open admissions institution. All students who have earned a high school diploma or GED are eligible for admission. In addition to an application for admission, students are required to supply the College with an official copy of their high school transcript or official copy of their GED scores. Students transferring from another college must submit an admissions application and an official copy of their transcript(s) from each college they have attended; in addition to their high school transcripts or GED scores if they did not complete a baccalaureate degree. Transient students must submit a transient letter from their home institution stating the courses they will be allowed to take in addition to an application for admission, Proof of ID, and Residency Form.

Graduates from a non-accredited high school with a diploma demonstrating successful completion of a course of study on the secondary level based upon the Carnegie units required by the state education agency at the time of the award (currently 24) are eligible for admission. If the above requirements are not met, the student must take a GED test.

Special requirements may apply to International Students seeking admission. International students must submit official transcripts, an I-20 Form, TOEFL scores, declaration of responsibility statement, proof of insurance, and all appropriate admissions forms. Further information is available in the college catalog.

Accelerated high school students who have completed the

tenth grade, have the required GPA, and are recommended by the local principal may enroll at Wallace State only in postsecondary courses for which high school prerequisites have been completed. Exceptions may apply for students documented as "gifted and talented" according to the standards included in the State Plan for Exceptional Children and Youth.

Visit Lion Central in the Bailey Center, or call 256.352.8236 or email lioncentral@wallacestate.edu for information about general admission.



Getting Started at Wallace State

- 1. ADMISSIONS:** Apply online at www.wallacestate.edu. Remember to send your transcripts, proof of identification and complete residency form.
- 2. FINANCIAL AID:** Information about financial aid, including scholarships, grants, loans, work-study, WIA, TRA and veterans' benefits, may be obtained by visiting www.wallacestate.edu and clicking on the Financial Aid Tab.
- 3. ORIENTATION:** All students are strongly encouraged to attend a LIONS' Pride Information Session. Incoming freshmen are required to register for an orientation course (unless exempt). Contact the Advising Center at 256.352.8040 for more information. The WSCC Office of Enrollment Management is available to provide college information and schedule campus tours. Call 256.352.8031 for more information.
- 4. TESTING:** All students must complete Placement Tests in English, reading, and mathematics prior to registering for classes. Testing is waived for those who present recent ACT scores (or SAT equivalent) of 18 on the English and 20 on the math portions. Contact the Testing Center at 256.352.8243 for more information.
- 5. ACADEMIC ADVISING:** Advisors are available to assist students in choosing a course of study, developing a degree plan, and registering for classes. Visit the Advising Center in Lion Central (256.352.8040) to see an advisor or contact your assigned faculty advisor. Advisor information is available on DegreeWorks at myWallaceState. See Page 4 for instruction.
- 6. REGISTRATION:** Students can register online at myWallaceState, accessible from the Wallace State home page, www.wallacestate.edu. For registration dates and times, consult the Important Dates (on Inside Cover) or visit www.wallacestate.edu.
- 7. FEE PAYMENT:** Registration is not complete until all tuition and fees are paid. Fees may be paid online, by mail, or in person at the WSCC Cashier's Office. Please consult the course schedule for a list of tuition and fees and important deadlines. For payment information, call 256.352.8015. Discover, American Express, Visa and Mastercard are accepted. If tuition and fees are not paid by deadline, schedules will be deleted.
- 8. CHECK BALANCE:** Students can view their balance via their myWallaceState account. To access your balance please follow these steps:
 1. Log on to your myWallaceState account.
 2. Click on the Student tab
 3. Click on My Tuition and Fees
 4. Click on Payment Options.

Wallace State Community College
Proof of Identification Documentation

All applicants must provide one (1) primary form of identification.

Examples of primary forms of identification include:

- Unexpired Alabama Driver's License or instruction permit
- Unexpired Alabama identification card
- Unexpired US Passport
- Unexpired US Permanent Resident Card
- Resident Alien Card – Pre-1997
- Unexpired Driver's License or instruction permit from another state or possession that verifies lawful presence, dated 2000 and beyond
- US Alien Registration Receipt Card (Form I-151) prior to 1978
- BIA or tribal identification card with photo
- I-797 Form with expiration date

Forms will be accepted the following ways:

- In person at the Lion Central desk in the Bailey Center
- Via mail - the copy should be clear and on this form
Office of Admissions
PO 2000
Hanceville, AL 35077
- Faxed copies will **not** be accepted

APPENDIX A

According to State Board Policy 801.01: Admission: General, all students must provide one primary form of identification for admission to Alabama community colleges.

One primary form of identification

Type of Identification: _____

Signed _____ Date _____
College Representative