

## ARTS

# Student Registration (**Registrar's Office**)

**Please complete this form and forward to:**

**Denise Davis**

Co-coordinator, Specialist High Skills Major (SHSM) Programs  
c/o L. Saari, Education Pathways, Development and Quality  
Niagara College  
Room E102, 135 Taylor Rd.  
Niagara on the Lake, ON L0S 1J0  
ddavis@niagaracollege.ca

**Please print clearly, in pen:**

Student Name:	
Street Address:	
City, Postal Code:	
Phone: Home	Cell
Email Address:	
D.O.B. (dd/mm/yyyy)	
Niagara College ID# (if existing)	
School Board:	<input type="checkbox"/> DSBN <input type="checkbox"/> NCDSB
Home School:	
Student Success Team/Guidance:	
F.O.I signed/attached	Please Circle: <b>Yes</b>

## ARTS

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### (Registrar's Office)

## Consent to the Disclosure or Release of Admissions and/or Registration Information (Freedom of Information)

Office of the Registrar,

I understand that Niagara College of Applied Arts and Technology (the College) is required to comply with the provisions of the Freedom of Information and Protection of Privacy Act (the Act) by giving me notice of any request for disclosure of personal information about me, which includes information about my educational history.

I hereby agree that the College need not give me notice and need not comply with the Act but may and is hereby authorized to release any information about my educational history, including my marks, to the Coordinator of the SHSM program at Niagara College as well as the appropriate School Board:

- District School Board of Niagara
- Niagara Catholic District School Board

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Date of Birth (day/month/year)

\_\_\_\_\_  
Date (day/month/year)

\_\_\_\_\_  
Niagara Student ID (upon college registration)

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Parent/Guardian  
(If student under 18 years of age)

\_\_\_\_\_  
Signature of Witness

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

**The student may rescind or amend this authorization in writing at anytime prior to the expiry date.**

Expiry Date: March 31, 2013

*Unless an Expiry Date is specified, this consent will continue to be valid until such time as it is revoked, in writing, by me.*

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**Student Information** (please print):

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Please provide a brief explanation of why you are applying to the Specialist High Skills Major (SHSM) program:

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/Student Information (cont'd)

**ARTS**

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**School Information** (to be completed by school):

Home School: \_\_\_\_\_

School Telephone Number: \_\_\_\_\_

This student candidate would benefit from participation in this program for the following reason(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This student application is supported by the Student Success Team

Student Success Team Member/Guidance Teacher: \_\_\_\_\_

Email: \_\_\_\_\_

Principal/designate name & signature: \_\_\_\_\_

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

Application Deadline:

**December 15, 2011** or sooner

*Information collected will be used for the sole purpose of delivering the SHSM initiative. Information will not be shared outside of the delivery partners for this initiative.*