

DIAGNOSTIC VISIT APPLICATION



School Name _____ Phone (____) _____
Address _____ Fax (____) _____
City _____ LCMS District _____
State _____ Zip _____ Principal _____
Email _____

Operating LCMS Congregation(s) Name _____
City, State _____ Pastor _____

Primary Contact Person

Name _____ Home Phone (____) _____
Address _____ Work Phone (____) _____
City _____ Cell Phone (____) _____
State _____ Zip _____ Fax (____) _____
Email _____
Position _____

We, the undersigned, on behalf of the school and congregation(s) listed above:

- desire the LSCS diagnostic visit and three follow-up visits over an 18-month period
- are willing to address the recommendations of the diagnostic team in developing our plan for improvement
- will provide the leadership to implement change

_____	_____	Date _____
Pastor Signature	Printed Name	
_____	_____	Date _____
Principal Signature	Printed Name	
_____	_____	Date _____
School Board Chair Signature	Printed Name	
_____	_____	Date _____
Congregation Chair Signature	Printed Name	

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Attach the following required information.

1. The school budget and expenditures for the past three years.
2. Enrollment by grade level (and/or preschool age) for the past five years.
3. LCMS school statistical reports for the current school year and additional two previous years, if available.
4. LCMS Lutheran Annual Forms for the current school year and additional two previous years, if available.
5. A two-page narrative written and signed by the primary contact person describing:
 - why LSCS services are requested
 - what you hope to gain as a result of the diagnostic visit
 - current difficulties, problems, and frustrations
6. \$500.00 application fee. This fee is refundable upon receipt of a detailed school improvement plan that addresses the LSCS recommendations; a LSCS consultant will assist in developing the school improvement plan. Check payable to: LCMS - LSCS

Submit this completed application, \$500 application fee, and attached documents to your LCMS District leader with responsibility for services to Lutheran elementary schools.

To be completed by LCMS District Office

Comments:

Name _____

District _____

Signature _____

Date _____

Send signed application and attached materials to:

The Lutheran Church-Missouri Synod
Attn: School Ministry, LSCS
1333 South Kirkwood Road
St. Louis, MO 63122-7295
(314) 996-1294
Fax (314) 996-1124