PART I
TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

PHYSICAL AND MEDICAL
DISABILITY DOCUMENTATION REQUEST FORM

Student’s Name: _______________________________________________________________________________

Phone Number: __________________________ Date of Birth: ________________________________

When did/will you start attending LSU? Semester_____________________ Year: _______________________

LSU I.D. Number: __________________________ LSU E-mail: ________________________________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a qualified professional provide current and comprehensive documentation. A qualified professional includes a licensed medical doctor or other qualified healthcare professional who is not a family member of the student.

• If it is a visual disability, the documentation must include the student’s visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

• In addition to completing the form below, an audiogram completed by a licensed audiologist must also be submitted for students who are deaf or hard of hearing.

**** This form must contain ALL of the requested information below in order to apply for accommodations through Disability Services. ****

1. Diagnosis (as diagnosed by the DSM-5) ____________________________________________________________

2. Date of Diagnosis: ______________________ Date of Last Contact with Student: ______________________

3. Provide a summary of the student’s educational, medical, and family history that relates to the physical or medical disability (must demonstrate difficulties are not the result of other conditions, cultural differences, or insufficient instruction): __________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

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__________________________________________________________________________________________
4. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

5. List \textbf{current medication}, along with any \textbf{current side effects} that may impact academic performance: 

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

6. Please indicate below the \textbf{RECOMMENDATIONS} you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student’s educational opportunities at LSU as justified based on the functional limitations indicated above.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Qualified Professional’s Signature: ____________________________________________________________
Printed Name & Title: _______________________________________________________________________
License or Certification Number: ________________________________________________________________
Daytime Telephone Number: __________________________________________________________________
Address: _________________________________________________________________________________
Date: ____________________________________________________________________________________

\textbf{Disability Services}  
\textbf{Louisiana State University}  
\textbf{124 Johnston Hall}  
\textbf{Baton Rouge, LA 70803}  
\textbf{Phone: 225-578-5919}  
\textbf{Fax: 225-578-4560}
PART II
TO BE COMPLETED BY STUDENT

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

REQUEST FOR ACCOMMODATIONS

Student’s Name: ________________________________________________________________

Phone Number: ___________________________________ Date of Birth: __________________

When did/will you start attending LSU?  Semester_________________________ Year: ______________________ 

LSU I.D. Number: ____________________________ LSU Email: ______________________________

LSU enrollment for which you are requesting accommodations (check below):

□ LSU A&M (Main Campus)  □ LSU Law Center  □ Vet School □ LSU Online

□ Independent and Distance Learning (Enrollment #) __________________________

I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment (check all that apply):

Attention Deficit Hyperactivity Disorder (ADHD)

Learning Disability

Deaf & Hard of Hearing

Psychological Disability (specify): ________________________________________________

Physical or Medical Disability (specify): ____________________________________________

Temporary Disability (specify): ____________________________________________________

In the space below, please list and explain the reason for each of the accommodations you are requesting.

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Signature of Student: _______________________________________ Date: ______________________________

*Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.