PART I
TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

PSYCHOLOGICAL 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 Email: ________________________

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 is a licensed mental health professional who is not a family member of the student.

**** 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 psychological disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction): ________________________________

4. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting: __________________________________________
5. List current medication along with any current side effects that may impact academic performance: 

6. Please indicate below the 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: ________________________________
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.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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_____________________________________________________________________________________________

Signature of Student: _______________________________ Date: ______________________________

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