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 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 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: _______________________________________ _________________________________________

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):
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
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: ________________________________________________________________________________________

Disability Services
Louisiana State University
124 Johnston Hall
Baton Rouge, LA 70803
Phone: 225-578-5919
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.