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: ________________________________
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 (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):  __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

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:

[long line for input]

6. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student’s educational opportunities at LSU as justified based of the functional limitations indicated above.

Please check all that apply:

- [ ] Extended Time (1.5X)
- [ ] Distraction Reduced Environment
- [ ] Consideration for Absences
- [ ] No Scantron
- [ ] Note-Taking
- [ ] E-text
- [ ] Enlarged Text (font size ___)
- [ ] Reader
- [ ] Scribe
- [ ] Other __________________________________________

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: _______________________

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.