Division of Enrollment & Student Engagement

Part One: Disability Services Documentation
Completed by Evaluator

Student's Name: _____

Phone Number: _____ Date of Birth: _____

When did/will you start attending LSUA? Semester _____ Year: _____

LSUA ID Number: _____ LSUA 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 psychiatrist, psychologist, medical doctor, or other qualified 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: _____

2. If you have a formal evaluation, please attach it.

3. Date of Diagnosis: _____ Date of Last Contact with Student: _____

4. Provide a summary of the student's educational, medical, and family history that may relate to disability (must demonstrate that difficulties are not the result of other conditions, cultural differences, or insufficient instruction):

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

6. List **current medication**, along with any **current side effects** that may impact academic performance:

7. 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 LSUA 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: _____

Louisiana State University *of* Alexandria
Disability Services
Room W209A, Student Center
8100 Hwy US 71 South
Alexandria, LA 71302
disabilityservices@lsua.edu
318-427-0137

Part Two: Accommodations Request
Completed by Student

Student's Name: _____

Phone Number: _____ Date of Birth: _____

When did you start attending LSUA? Semester: _____ Year: _____

LSUA ID Number: _____ LSUA Email: _____

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)

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 requested accommodation.

_____

_____

_____

_____

_____

_____

Signature of Student: _____ Date: _____