LSUE | Office of Disability Services

PO Box 1129 • Eunice, LA 70535
Science Building Room 145
337-550-1204 • Fax 337-550-1268
www.lsue.edu/studentaffairs • ods@lsue.edu

# PSYCHOLOGICAL DISABILITY DOCUMENTATION REQUEST FORM

*(TO BE COMPLETED BY QUALIFIED PROFESSIONAL)*

*When completing this form, please PRINT or TYPE and COMPLETE ALL FIELDS.*
*Incomplete forms will not be accepted.*

****** If you have a formal evaluation, please attach the documentation.******

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 of the disability. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified medical or mental health professional **who is not a family member of the student**. **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S EVALUATION MUST BE WITHIN THREE (3) YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FOR DISABILITY ACCOMMODATIONS.**

**Student's Name: _____ LSUE ID Number: _____**

**Date of Birth: _____**

**Mailing Address _____ City & Zip Code _____**

**Phone Number: _____**

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

**2. Date of Diagnosis: _____ Date of Last Contact with Student: _____**

**3. For the purpose of determining academic adjustments, describe the severity and longevity of the substantial limitations due to a learning disability.**

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

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

6. **Please indicate the RECOMMENDATIONS you have regarding reasonable and appropriate auxiliary aids or services, academic adjustments or other accommodations to ensure equity for the student's academic success based on the functional limitations indicated above.**

**Please check all that apply:**

☐ Extended Time (1.5X) ☐ Distraction Reduced Environment

☐ Alternative Test Format ☐ Consideration for Absences ☐ No Scantron

☐ Books on Tape ☐ Enlarged Text (font size ___) ☐ Reader ☐ Scribe

☐ Other _____

**Qualified Professional's Signature: _____**

**Printed Name & Title: _____**

**Daytime Telephone Number: _____**

**Address _____ City & Zip _____**

**Date: _____**

**Submit this form and all necessary documentation via scan/email, fax, mail, or in person to:**

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Louisiana State University Eunice
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# REQUEST FOR ACCOMMODATIONS

*(TO BE COMPLETED BY STUDENT)*

**Student's Name:** _____ **LSUE ID Number:** _____

**Date of Birth:** _____

**Mailing Address** _____

**City & Zip Code** _____

**Phone Number:** _____

**I am requesting accommodations because I have been diagnosed with one or more of the following disabilities that substantially limit and impair my ability to perform in an academic environment (Check all that apply):**

☐ *Attention Deficit/Hyperactivity Disorder*
☐ *Psychological Disability*
☐ *Physical or Systemic (Medical) Disability (specify):* _____
☐ *Learning Disability*
☐ *Deaf & Hard of Hearing*

In the space below, list and explain **the reason for each of the accommodations you are requesting.** *What accommodations, if any, have you received in the past? (i.e. during high school etc.)* Please be as specific as possible.

**Signature of Student:** _____ **Date:** _____

*NOTE: The Office of Disability Services does not provide copies of any documentation. ODS strongly recommend maintaining copies of any submitted documentation for your personal records.*