



PO Box 1129 • Eunice, LA 70535

Science Building Room 145

337-550-1204 • Fax 337-550-1268

[www.lsu.edu/studentaffairs](http://www.lsu.edu/studentaffairs) • [ods@lsue.edu](mailto:ods@lsue.edu)

## PHYSICAL AND SYSTEMIC (MEDICAL) 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:

Office of Disability Services  
Louisiana State University Eunice  
PO BOX 1129 • Eunice, LA 70535  
Science Building Room 145  
Phone: 337-550-1204 • Fax: 337-550-1268  
Email: ods@lsue.edu



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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):

- |   |   |
|---|---|
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder                   | <input type="checkbox"/> Learning Disability    |
| <input type="checkbox"/> Psychological Disability                                   | <input type="checkbox"/> Deaf & Hard of Hearing |
| <input type="checkbox"/> Physical or Systemic (Medical) Disability (specify): _____ |   |

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.*