

# LSUA | Disability Services

## 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 the information requested below for eligibility consideration.**

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):

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

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

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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.

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Qualified Professional's Signature: \_\_\_\_\_

Printed Name & Title: \_\_\_\_\_

License or Certification Number: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

**Louisiana State University of Alexandria**  
Disability Services  
Martin Family Student Success Center Room 2209  
8100 Hwy US 71 South  
Alexandria, LA 71302  
disabilityservices@lsua.edu  
318-427-4491

**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.**

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**Signature of Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_