

**PART I
TO BE COMPLETED BY EVALUATOR**

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

PSYCHOLOGICAL DISABILITY DOCUMENTATION REQUEST FORM

Student's Name: _____

Phone Number: _____ Date of Birth: _____

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

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 is a licensed 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 (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 psychological disability (difficulties must be related to the diagnosed disability and 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: _____

6. 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 LSU 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: _____

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: _____

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

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.**