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: ________

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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.

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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
Email:disability@lsu.edu

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.

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Signature of Student: ______________________ Date: ______________

***Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.**

Division of Student Affairs
Disability Services

CONSENT TO RELEASE

I, ____________________________________*(student/incoming student)***,** understand that the

information contained in my record is confidential. However, I give my consent for

DISABILITY SERVICES

to release to ____*(parent, guardian, other)*

the following specific information: **DISABILITY AND ACADEMIC**

The above-listed information is to be disclosed for the specific purpose of

ACCOMMODATIONS and UNIVERSITY SUPPORTS.

This consent is subject to written revocation OR cancellation signature at any time except to the extent that action has already been taken upon this consent. All releases are done on roughly an annual basis regardless of any date changes to the form with all releases expiring at the end of the upcoming academic year.

This consent will automatically expire **AUGUST 31, 2022**.

____
Signature of Student/Client

____
LSU ID#

____
Date

I wish to cancel this Consent to Release effective _________________.
Date

____
Signature of Student/Client