

**UNO Disability Services
Prospective Disability Student Packet**

Documentation Release Form

I, _____, request that written, specific documentation supporting my disability (evaluations, reports, or other data) be forwarded to:

University of New Orleans
2000 Lakeshore Drive
Office of Disability Services
Division of Student Affairs
New Orleans, LA 70148

Student/Prospective Student

Witness

Date

**UNO Disability Services
Prospective Disability Student Packet**

DOCUMENTATION REQUEST FORM

THIS FORM MUST CONTAIN ALL OF THE REQUESTED INFORMATION AND ***MUST BE TYPED OR LEGIBLY HAND-WRITTEN*** IN ORDER TO APPLY FOR ACCOMMODATIONS THROUGH DISABILITY SERVICES.

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Student ID Number: _____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services due to disability. 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 health professional.

The documentation provided must include a clear diagnosis, and the purpose of determining academic adjustment(s) or other accommodation(s).

To facilitate the gathering of such critical information, please respond legibly to the following and return to UNO, Disability Services.

1. Diagnosis: _____

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

3. What procedures were used to assess/diagnose the student? **A copy of the diagnostic report must be attached.** _____

4. Describe the symptoms that meet the criteria for diagnosis with approximate date of onset: _____

5. Describe the student's functional limitations in an educational setting as it relates to the above diagnosis and the student's request/noted recommendations for academic accommodations: _____

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6. Is this student taking any medication? If yes, please list medication(s), dosage(s), date of initial prescription and side effects of the medication: _____

7. Will the student continue to need accommodations when utilizing medication(s)? _____

8. Please indicate the **RECOMMENDATIONS** you have regarding auxiliary aids or services, academic adjustments or other accommodations to equalize the student's educational opportunities at UNO.

Please check all that apply: extended time (1.5x) distraction-reduced environment for testing
 alternative test format no scantron volunteer note taker

other (for example, but not limited to or inclusive of parking considerations, reasonable allowances for absences clearly based on the impact of the disability/diagnosis, testing time extension beyond 1.5 time

9. In addition to the diagnostic report, please attach any additional information that you feel is relevant in determining appropriate accommodations for this student.

Qualified Professional's Signature: _____

Printed Name & Title: _____

Daytime Telephone Number: _____

Address: _____

Date: _____

Please return the original form to:

Attach business card below (required)

University of New Orleans
2000 Lakeshore Drive
Office of Disability Services
Division of Student Affairs
New Orleans, LA 70148
Phone: 504-280-7284