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
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