University of New Orleans, Accessibility Services Office
DOCUMENTATION REQUEST FORM

STUDENT
Please complete the top portion of this form and sign before providing it to the Qualified Professional to complete.

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Student ID Number: _____

I am 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 I provide documentation from a Qualified Professional. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified health professional.

Student's Signature: _____

The SECTION BELOW MUST CONTAIN ALL OF THE REQUESTED INFORMATION AND MUST BE TYPED OR LEGIBLY HAND-WRITTEN BY THE QUALIFIED DIAGNOSING PROFESSIONAL.

The health care provider need not use this specific form, but all the information requested here is necessary for the institution to have in order to consider the request for accommodation. This information can be provided in another format.

1. Federal law defines a person with a disability as someone who has a physical or mental impairment that substantially limits one or more major life activities. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation). What is the nature of the student's impairment (that is, how is the student substantially limited?):
   _____
   _____
   _____
   _____

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/psychoeducational report <u>must</u> be attached if applicable**.
   _____
   _____
   _____

4. Describe the student's functional limitations in an educational setting as it relates to the above diagnosis:
   _____
   _____
   _____
   _____
   _____
   _____
   _____

5. If this student is taking any medication which has side effects that may impact the student, please note here:

   _____

   _____

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

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

   Please check all that are recommended:
   ___ extended time for testing (1.5x/2x)
   ___ distraction-reduced testing environment
   ___ use of technology such as recording, computer use for typing notes
   ___ note taking assistance
   ___Other (please be specific and include how the requested accommodation relates to a noted functional limitation):

   _____

   _____

   _____

   _____

8. 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:

University of New Orleans
2000 Lakeshore Dr.
Accessibility Services Office
Earl K. Long Library Room 126E
New Orleans, LA 70148
Phone: (504) 280-7327
Email: accessibility@uno.edu

Please affix a business card below.