University of New Orleans, Office of Student Accountability & Disability Services

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 must be attached if applicable.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

5. Describe the student’s functional limitations in an educational setting as it relates to the above diagnosis:

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

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

8. 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):
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

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 affix a business card below.

Please return the original form to:
University of New Orleans
2000 Lakeshore Dr.
Office of Disability Services
Earl K. Long Library Room 126E
New Orleans, LA 70148
Phone: (504) 280-7284
Email: aaking@uno.edu