Xavier University of Louisiana
Office of Disability Services

PSYCHOLOGICAL DISABILITY
Documentation Request Form

This form must contain all the requested information and be typed or printed in order to apply for accommodations through the Office of Disability Services (ODS).

Student's Name: _____ Today's Date _____

Date of Birth: _____ Phone # _____ XU ID# _____

Address: _____ City _____ State _____ Zip _____

I hereby authorize the qualified professional to release to Xavier University of Louisiana's Office of Disability Services any pertinent information from my records related to the request below.

_____ _____

Signature of Student Date

TO BE COMPLETED BY A QUALIFIED PROFESSIONAL

This student is requesting service, academic adjustment, and/or other accommodation(s) from the Office of Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate 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 mental health ***who is not a family member or family friend of the student.*** **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S STATEMENT MUST BE WITHIN 6 MONTHS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM DISABILITY SERVICES.**

The documentation provided must include information that indicates a diagnoses of a psychological disability (as diagnosed by the DSM-5), describes the functional limitations in an educational setting, and indicates the severity and longevity of the psychological disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication and any current side-effects which may impact academic performance.

To facilitate the gathering of such critical information, please respond to the following and return to XAVIER UNIVERSITY OF LOUISIANA, Office of Disability Services.

1. Diagnosis _____ Date of Diagnosis: ____/____/____ Date of Last Contact with Student: _____/_____/_____

2. 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):

_____

_____

_____

_____

_____

_____

(OVER)

3. Describe the student's **functional limitations** in an educational setting:

_____

_____

_____

4. List **current medication** along with any **current side-effects** which may impact academic performance:

_____

_____

_____

5. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate services, academic adjustments, or other accommodations to equalize the student's educational opportunities at XAVIER UNIVERSITY OF LOUISIANA as justified based on the functional limitations indicated above.

Please check all that apply:

_____extended time (1.5x) _____distraction-reduced environment

_____dining accommodations (explain)_____

_____housing accommodations (explain)_____

_____other_____

_____

Qualified Professional's Signature: _____ Date _____

Printed Name & Title: _____

Daytime Telephone Number: _____

Address: _____ City _____ State _____ Zip _____

NOTE: ***Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone*.**

Please return this form directly to:

Xavier University of Louisiana
Counseling and Wellness Center
Office of Disability Services
1 Drexel Drive Box D
New Orleans, LA 70125
Phone: (504) 520-7315
Fax: (504) 520-7943

A Business Card
Must Be Attached Here