Xavier University of Louisiana

Office of Disability Services
Referral Form

Date_____

Student's Name_____

Classification_____ **Major**_____

Referred by: _____

Dept._____ **Campus Ext.**_____

Reason for referral:

_____

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_____

Referring Person's Signature **Date**

_____

Send form to: Office of Disability Services Box D or
Fax form to: (504)-520-7943