

# Xavier University of Louisiana Office of Disability Services

## PHYSICAL AND SYSTEMIC (MEDICAL) 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 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 medical doctor, or other qualified health professional *who is not a family member of the student*.

The documentation provided must include information that diagnoses a physical or systemic (medical) disability, describes the functional limitations in an educational setting, and indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s) and lists current medication along with any current side-effects which may impact academic performance. **ALL DOCUMENTATION MUST BE UPDATED EVERY THREE (3) YEARS.**

If it is a visual disability, the documentation must include the student's visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

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 \_\_\_\_\_ Temporary or Permanent?
2. Date of Diagnosis: \_\_\_\_\_ Date of Last Contact with Student: \_\_\_\_\_
3. Provide a summary of the student's educational, medical, and family history that relates to the physical or systemic (medical) disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(OVER)

4. Describe the student's **functional limitations** in an educational setting: \_\_\_\_\_

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

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6. 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:

<input type="checkbox"/> Extended time (1.5x)	<input type="checkbox"/> Housing Accommodations ( <b>explain below</b> )	<input type="checkbox"/> No scantron
<input type="checkbox"/> Distraction-reduced environment	<input type="checkbox"/> Meal Plan Accommodations ( <b>explain below</b> )	<input type="checkbox"/> Books on tape
<input type="checkbox"/> Alternative test format	<input type="checkbox"/> Enlarged text (font size _____)	
<input type="checkbox"/> Other _____		

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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*

