



XAVIER UNIVERSITY OF LOUISIANA
Office of Disability Services
 1 Drexel Drive • Box 180
 New Orleans, Louisiana 70125-1098
 (504) 520-7607 • FAX (877)856-7734

CERTIFICATE OF DISABILITY

Office of Disability Services
Student Certificate of Disability Form

Dear Student,

This form is designed to provide The Office of Disability Services with confirmation that you have a disability and with information on how your disability will impact your studies at the university. See last page for more information on documentation for a learning disability, ADHD and psychiatric/psychological disabilities.

The mandate of The Office of Disability Services is to provide reasonable and appropriate academic accommodations while maintaining academic integrity of the degree. The Office of Disability Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying. Please bring this form to a health care professional who knows you well.

Disclosing a mental health diagnosis is a choice and is **not** required to receive accommodations. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis.

This form must be completed by a qualified healthcare provider (**Health Care Providers must be certified/accredited** in one of the following categories: **MD, Ph.D., Psy.D., and LCSW**) and submitted to the Office of Disability Services.

ATTENTION STUDENT: This document, once completed by your qualified healthcare provider, should be submitted to the Office of Disability Services, located in the Convocation Center Annex – Room 215, or you can fax a copy to (877) 856-7734. **Remember, before your accommodation is approved all required forms and documentation must be received by the Office of Disability Services.**

ATTENTION HEALTH CARE PRACTITIONER: If you are preparing this form for a student registering with The Office of Disability Services, the student has a separate questionnaire that they must complete and submit to The Office of Disability Services. If you will be submitting this form directly to our office on behalf of the student, please mail to: **Disability Services, 1 Drexel Drive, Box 180, New Orleans, LA 70125-1098**

STUDENT INFORMATION

Date of Request _____ Semester: Fall ____ Spring ____ Summer ____ Year: ____ Date of Birth: ____ / ____ / ____

Student Name: _____ Student ID Number _____

Email: _____ Contact Phone Number: _____

What accommodations are you requesting? _____

RELEASE OF INFORMATION (Please indicate below if you give consent for your healthcare provider to disclose your diagnosis)

I hereby authorize my Health Care Practitioner named here: _____ to share information concerning the functional impact(s) of my disability with The Office of Disability Services at Xavier University of Louisiana.

Student's Signature: _____ **Date** _____

CONSENT TO DISCLOSURE OF MENTAL HEALTH DIAGNOSIS TO THE OFFICE OF DISABILITY SERVICES

- I consent to my mental health diagnosis being identified on this form and provided to The Office of Disability Services at Xavier University of Louisiana.
- I do not consent to my mental health diagnosis being identified on this form.

Student's Signature: _____ **Date** _____



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Student Name: _____ Student XULA ID Number: _____

Health Care Provider with Authority to Make a Relevant Diagnosis

You have been asked by a student who wishes to register with The Office of Disability Services at the Xavier University of Louisiana to complete the enclosed documentation. The Office of Disability Services supports students who **require academic accommodation for a permanent or temporary disability**. Interim accommodations may be provided for students being assessed for mental health disabilities.

The purpose of the documentation is to enable the Office of Disability Services to recommend reasonable and appropriate academic accommodations for students with disabilities who experience functional restrictions and limitations affecting their performance in academic classroom/lab. The post-secondary environment involves taking examinations, and generally assuming personal responsibility for one's higher education pursuits

We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact on their learning and demonstrating their knowledge and skills.

Documentation must be provided by a regulated Health Care Practitioner licensed to diagnose.

HEALTH CARE PRACTITIONER INFORMATION

Name of Health Care Practitioner <i>(please PRINT):</i>					
Facility Name and address - <u>Please use official stamp</u> Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.		Specialty:		<input type="checkbox"/> Optometrist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Speech Language Pathologist <input type="checkbox"/> Other regulated health practitioner: _____	
		<input type="checkbox"/> Audiologist <input type="checkbox"/> Family Medicine <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Neuropsychologist <input type="checkbox"/> Neurosurgeon <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Ophthalmologist			
Health Care Practitioner Signature:				Registration/ License No.	
Date		Telephone Number		Fax Number	

DISABILITY VERIFICATION

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student’s type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as “suggests” or “is indicative of”. **If the diagnostic criteria are not present, this must be stated in the report.**

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Please note any multiple diagnoses or concurrent conditions.

Nature of Disability	Primary Disability <i>Indicate ONE only</i>	Date of Diagnosis Diagnosed by you <input type="checkbox"/> Yes / <input type="checkbox"/> No	Reviewed other Documentation	Other Disability(ies) <i>Indicate ALL that apply</i>	Date of Diagnosis Diagnosed by you <input type="checkbox"/> Yes / <input type="checkbox"/> No	Reviewed other Documentation
Acquired Brain Injury	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Attention Deficit (Hyperactivity) Disorder	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Autism Spectrum Disorder	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Chronic Physical Illness	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Deaf, Deafened, Hard of Hearing	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Low Vision, Blind	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Mental Health	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Physical Mobility	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Other*	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No

***Reminder: For ADD/ADHD, LD and psychiatric / psychological disabilities see documentation guidelines on pages 10 - 11. A regulated Health Care Practitioner may make an ADD/ADHD diagnosis.**

Diagnosis: DSM / ICD (text and code) _____ Date of Diagnosis: _____

Date of Last Clinical Contact w/ Student _____

DURATION:

Permanent disability with on-going (chronic or episodic) symptoms (that will impact the student over the course of their academic career and is expected to remain for their natural life).

Temporary with anticipated duration from: ____/____/____ to ____/____/____ (Year, Month, Day).

If duration is unknown, please indicate reasonable duration for which the student should be accommodated/supported (please specify): _____ (number of weeks, months) **or term ending:** Spring Summer Fall

Must be reassessed every _____ due to the changing nature of the illness or requires follow up for monitoring.

I am in the process of monitoring and assessing the student’s health condition to determine a diagnosis and this assessment is likely to be completed by (Please Note: Updated documentation will be required to continue to provide academic accommodations).

Date of Next Clinical Assessment ____/____/____ (Year, Month, Day), Interim accommodations may be provided during the assessment period. Updated documentation will be required to provide continued accommodation.

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

How did you arrive at this diagnosis? Select all that apply:

- Clinical Assessment.** (please provide a copy of the Assessment) Dates: _____
- Diagnostic Imaging/ Tests.** Please indicate all that apply: MRI CT EEG X-Ray
- Neuropsychological Assessment** (please provide a copy of the report which includes the list of tests completed and the scores)
- Psychiatric Evaluation.** (please provide a copy of the evaluation) Dates: _____
- Psycho-Educational Assessment** (please provide a copy of the evaluation report)
- Behavioral Observations:** _____
- Other:** _____

Functional Limitations: (Please describe)

ACQUIRED BRAIN INJURY/CONCUSSION

Date of Acquired Brain Injury/Concussion: _____

Prior history of Acquired Brain Injury/Concussion? Yes No Unknown

Description of the current injury and its impact on functioning i.e., the ability to meet academic/placement and other related student obligations:

HEARING Please attach a copy of the most recent audiogram. Symptoms are: Stable Progressive

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus (please check)		
Other (please specify):		
Does the student's hearing fluctuate? If so, please describe:		

VISION Symptoms are: Stable Progressive

Dx:

	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				

CURRENT TREATMENT			
Treatment	Start Date	Anticipated End Date	Frequency
Chiropractic Therapy			
Massage Therapy			
Neuropsychological Assessment/Counseling			
Occupational Therapy			
Outpatient ABI Treatment Program			
Physiotherapy			
Psychotherapy			
Speech Language Therapy			
Other			

How long have you been treating the student? _____ First visit: _____ Last visit: _____

Do you monitor and or treat the student on a regular basis? Yes No

MEDICATION TREATMENT

Current Medications:

Medication Side Effects: When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning: _____

Level of Impact (by medication) on Academic Functioning:

Mild Moderate Severe N/A

Please list side effects of medication(s) which may impact academic functioning:

Headaches and Migraines

<input type="checkbox"/> Headaches	Triggers:
	Impact:
<input type="checkbox"/> Migraines	Triggers:

SEIZURES

Type of Seizure	Management <i>(e.g., rarely occurs; well controlled with medication; needs rest or break; always call 911)</i>
<input type="checkbox"/> Focal (partial seizures), with retained awareness	
<input type="checkbox"/> Focal (partial seizures) with loss of awareness	
<input type="checkbox"/> Absence seizures (petit mal)	
<input type="checkbox"/> Tonic-Clonic/convulsive seizures (grand mal)	
<input type="checkbox"/> Atonic seizures (drop attacks)	
<input type="checkbox"/> Clonic seizures	
<input type="checkbox"/> Tonic seizures	
<input type="checkbox"/> Myoclonic seizures	
<input type="checkbox"/> Psychogenic non-Epileptic seizures	

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

VISION	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Eye fatigue/strain after _____ minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Restricted ability to view screen and read academic material	<input type="checkbox"/> >1hr	<input type="checkbox"/> 30-60 mins.	<input type="checkbox"/> <15 mins.	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PHYSICAL	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Ambulation <input type="checkbox"/> Short Distance <input type="checkbox"/> Other (e.g., uneven ground)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing (e.g., sustained standing in laboratory) <input type="checkbox"/> No prolonged standing, specify mins. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting for sustained period of time (e.g., in lecture /exam) <input type="checkbox"/> No prolonged sitting, specify mins _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This section to be completed by Regulated Health Care Practitioner

PHYSICAL (Continued)	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Stair Climbing <input type="checkbox"/> None <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting/Carrying/Reaching <input type="checkbox"/> No lifting/carrying more than _____ lbs. <input type="checkbox"/> Limited reaching/pushing/pulling <input type="checkbox"/> Limited ROM (specify) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grasping/Gripping Dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Minimize repetitive use <input type="checkbox"/> Limited dexterity (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck <input type="checkbox"/> No prolonged neck flexion <input type="checkbox"/> Reduced ROM <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain <input type="checkbox"/> Chronic <input type="checkbox"/> Episodic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin <input type="checkbox"/> Avoid contact with _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel and Urinary <input type="checkbox"/> Frequent (which may impact academic activities such as writing an exam) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stamina <input type="checkbox"/> Reduced stamina <input type="checkbox"/> Frequency of rest breaks (e.g., minutes per hour) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SLEEP CYCLES & ENERGY	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Fatigue <input type="checkbox"/> Temporary due to medication side effects. Expected duration: _____ <input type="checkbox"/> Fluctuating energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorder or difficulties _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Note: Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school.
COGNITIVE	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Concentration difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with organization/time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This section to be completed by Regulated Health Care Practitioner

COGNITIVE (continued)	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Executive functioning (ability to multitask, prioritize, organize and manage time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty staying on and completing tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judgement and insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with managing workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Becomes overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Need to ask for additional clarification and feedback on performance in lab/clinical/ placements/practicum/ related learning,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other impacts and restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PARTICIPATION/SOCIAL INTERACTION	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Significant difficulty in social participation (<i>This may cause difficulties with participating in class and group settings</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Significant difficulty related to speaking in public or presentations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty understanding common social cues (<i>e.g., do not pick up on metaphors, humor, facial expressions</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other impact and restrictions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH & SAFETY			Comments			
Difficulty operating machinery <i>(e.g. scientific or lab equipment, engineering machinery)</i>			<input type="checkbox"/> MILD: Should only operate with minimal supervision <input type="checkbox"/> MODERATE: Should only operate with constant supervision <input type="checkbox"/> SEVERE: Should never operate, with or without supervision			
Difficulty handling dangerous or hazardous substances/chemicals			<input type="checkbox"/> MILD: Should only handle with minimal supervision <input type="checkbox"/> MODERATE: Should only handle with constant supervision <input type="checkbox"/> SEVERE: Should never handle, with or without supervision			
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. <i>(e.g., seizure disorder, severe allergic reaction)</i>			If "Yes": please describe condition(s) and recommended response. Comments:			
Other: (please specify)						

SUPPORTS RECOMMENDED BY THE HEALTH CARE PROVIDER FOR UNIVERSITY LEARNING

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. Please provide your specific recommendations (based upon your assessment, the student’s clinical and academic history, and diagnosis). The Office of Disability Services will discuss these recommendations with the student to determine an appropriate accommodation plan. Please specify.

- Extended time for testing **1.5x**
- Extended time for testing **Double**
- Distraction reduced environment for testing
- Residential Accommodation(s) (**Specify below**)
- Emotional Support Animal (ESA)
- Other:

Health Practitioner’s Signature:

Date: