Disability Services

DOCUMENTATION REQUEST FORM

****This form must contain ALL of the REQUESTED INFORMATION and be TYPED or PRINTED in order to apply for accommodations through Disability Services.****

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

L#: _____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, College Policy requires that a Qualified Professional provide current and comprehensive documentation. A qualified professional is a licensed mental health professional *who is not a family member 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 diagnosis (must make a DSM-V diagnosis), describes the functional limitations in an educational setting, indicates the severity and longevity 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 SOWELA, Disability Services.

1. Diagnosis: _____

2. Date of Diagnosis: _____

3. Date of Last Contact with Student: _____

4. Provide a summary of the student's educational, medical, and family history that relates to the disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):

_____

_____

_____

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

_____

_____

_____

_____

_____

6. List current medication along with any current side effects that may impact academic performance:

_____

_____

_____

_____

_____

7. 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 SOWELA as justified based of the functional limitations indicated above.

Please check all that apply:

- ☐ extended time (1.5x)
- ☐ distraction-reduced environment
- ☐ scribe
- ☐ consideration for absences
- ☐ no scantron
- ☐ reader
- ☐ other _____

_____

Qualified Professional's Signature: _____

Printed Name & Title:_____

Daytime Telephone Number: _____

Address: _____

Date: _____

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.

SOWELA Technical Community College does not discriminate on the basis of race, color, national origin, gender, disability, or age in its programs and activities. The following person has been designated to handle inquiries regarding non-discrimination policies: Compliance Officer, 3820 Sen J Bennett Johnston Ave, Lake Charles, LA 70615, ph: 337-421-6565 or 800-256-0483, Email complianceofficer@sowela.edu