Dear __________________:

RE:

The above student has applied for supportive services available to qualified individuals with disabilities at LSU Shreveport. Current and comprehensive documentation of the student’s disability must be on file with SSD to determine appropriate and reasonable accommodations. The student has indicated that you could provide information pertinent to functioning in college.

Please address the criteria outlined below on professional letterhead OR complete the attached verification form. A signed release of information form is enclosed.

Thank you for your assistance.

Sincerely,

Paula B. Atkins
Dean of Students

CRITERIA FOR DOCUMENTING MEDICAL DISABILITIES

1. Clear identification of an actual diagnosis, including pertinent history.
2. A description of present symptoms, fluctuating conditions/symptoms, and prognosis.
3. Current documentation (the age of acceptable documentation is dependent upon the assessment’s relevance to the requested accommodations).
4. Discussion of functional limitations in an academic environment which are caused by the impairment.
5. Suggestions of reasonable accommodations to compensate for the limitations and which are supported by the diagnosis.
6. Current medication, dosages, and existing (not possible) side effects.
LSU SHREVEPORT
Services for Students with Disabilities
One University Place
Shreveport, Louisiana 71115
(318) 797-5116

VERIFICATION FORM

Student name: _____________________  Date: _____________________

Social Security Number: ____________  D.O.B. ____________________

DIAGNOSTIC INFORMATION

Current diagnosis: _______________________________________________________

Date of onset of current diagnosed disability: ____________________________

Pertinent history:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Summary of present symptoms:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
Prognosis:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

MEDICATION/TREATMENT INFORMATION

Describe current medication needs and side effects and how the medication will affect the student’s educational performance:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Is the student still adjusting to the medication or is the student stabilized on the medication:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

INFORMATION SUPPORTING ACCOMODATION REQUESTS

Describe the student’s functional limitations in an educational setting:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Describe any crisis episodes associated with the disability:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Describe any restrictions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How will the disability affect the student’s class attendance/participation (attend lectures, contribute to class discussions, do research, write papers, read large amounts of information, meet deadlines, work in small groups, etc.):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What recommendations are suggested to equalize this students educational opportunities at the post-secondary level? (Describe services/accommodations in exam administration, classroom or study activities, or course requirements.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
OTHER INFORMATION

Describe other accompanying disabilities and attach relevant documentation:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

CERTIFYING AUTHORITY

Print name and title: ____________________________

Signature: ____________________________________

Address: _____________________________________

Phone: _______________________________________

Signature: ____________________________________

Attach your business card:
RELEASE OF INFORMATION

I have requested academic adjustments or auxiliary aids through LSU Shreveport’s Services for Students with Disabilities based upon a medical impairment. To develop the most appropriate services, it is necessary to verify the disabling condition and the need for academic adjustments or auxiliary aids. I give my permission to ____________________________ to release records/information concerning my condition to the Coordinator of Services for Students with Disabilities for the purpose of educational planning.

Signed,

_______________________________        __________________________
Student                                 Witness

_______________________________
Social Security Number

_______________________________
Date

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