BRCC COUNSELING & ACCESSIBILITY SERVICES

DOCUMENTATION REQUEST FORM

DOCUMENTATION GUIDELINES

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from the Office of Counseling & Accessibility Services (CAS). To consider this request and ensure the provision of reasonable and appropriate aids and services, college policy requires that a **Qualified Professional** provide current and comprehensive documentation.

A Qualified Professional is a licensed professional (medical doctor, psychiatrist, psychologist, counselor, social worker, or other qualified healthcare or mental health professional) who is **not a family member of the student**.

Student's Name: _____ Date of Birth: _____

Address (Including City, State, & Zip Code: _____

Phone Number (Including Area Code): _____ Student Campus ID #: _____

FOR QUALIFIED PROFESSIONALS TO COMPLETE ONLY

This form must contain ALL information requested below for eligibility consideration**.**

TYPE OF DISABILITY (Check all that apply)

- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Physical/Systemic/Medical Disability
- ☐ Sensory Disability
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Psychological Disability
- ☐ ASD/Other Neurodevelopmental Disorder
- ☐ Communication Disorder

DIAGNOSIS/DIAGNOSES IMPACTING ACADEMIC FUNCTIONING

DSM-5 Diagnosis/ICD-10 Code: _____ Level of Severity: ☐Mild ☐Moderate ☐Severe

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DATE OF DIAGNOSIS AND LAST CONTACT

Date of Diagnosis: _____ Date of Last Contact with Student: _____

SUMMARY OF RELEVANT HISTORY: Provide a summary of the student's educational, medical, and family history as it relates to the diagnosis. Difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction.

_____

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_____

FUNCTIONAL LIMITATIONS IN AN EDUCATIONAL SETTING: Describe the student's functional limitations in an educational setting associated with the disability.

CURRENT MEDICATIONS AND SIDE EFFECTS: List current medications and any side effects that may impact academic performance.

RECOMMENDATIONS FOR ACCOMMODATIONS: Please indicate your recommendations regarding necessary and appropriate auxiliary aids, services, or other accommodations to equalize the student's educational opportunities as justified on the functional limitations indicated above.

CAS will only accept documentation if the qualified professional provides a certified electronic signature or physical signature.

Name & Title: _____

Signature: _____

License/Certification Number: _____

Address (Including City, State, & Zip Code): _____

Telephone Number (Including Area Code): _____

Date: _____

CAS strongly recommends maintaining copies of any submitted documentation for personal records.

Counseling & Accessibility Services Contact Information
Phone: 225.216.8643 | **Fax:** 225.216.8642 | **Email:** cas@mybrcc.edu