BATON ROUGE COMMUNITY COLLEGE

COUNSELING & ACCESSIBILITY SERVICES

PHYSICAL AND SYSTEMIC (MEDICAL) DISABILITY DOCUMENTATION REQUEST FORM

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Student Campus ID #_____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from the Office of Counseling & Accessibility 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 includes a medical doctor or other qualified healthcare professional **who is not a family member of the student**. **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM COUNSELING & ACCESSIBILITY SERVICES.**

- 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.

- In addition to completing the form below, an audiogram completed by a licensed audiologist must also be submitted for students who are **deaf or hard of hearing.**

******This form must contain ALL of the requested information below to apply for accommodations through the office of Counseling & Accessibility Services.******

1. Diagnosis: _____

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).

_____

_____

_____

_____

4. Describe the student's **functional limitations** in an educational setting (i.e., current and/or anticipated problems associated with the condition) in an educational setting: _____

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

6. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services, or other accommodations to equalize the student's educational opportunities at BRCC as justified based on the functional limitations indicated above. _____

Qualified Professional's Signature: _____

Printed Name & Title: _____

License or Certification Number:_____

Daytime Telephone Number: _____

Address: _____

Date: _____

PLEASE NOTE: Counseling & Accessibility Services **strongly recommends** maintaining copies of any submitted documentation for personal records.

Counseling & Accessibility Services
Phone: 225/216-8643 | Fax: 225/216-8642 | accessibilityservices@mybrcc.edu