**Delgado Community College**

**Office of Disability Services**

**Accommodation Referral Form**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LoLA ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby give consent for my clinician to disclose my medical/clinical evaluation for purposes of receiving reasonable accommodations.**

**Student Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please have your clinician complete below:**

**Primary Disability:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Disability:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this individual wheelchair bond?**  \_\_\_ yes \_\_\_ no

**Accommodation Type:**

\_\_\_ Preferential Seating \_\_\_ Distraction-Free Environment

\_\_\_ Extended Time (Test Only) \_\_\_ Use of Tape Recorder

\_\_\_ Extended Time (Tests and Assignments) \_\_\_ Frequent Breaks

\_\_\_ Reader \_\_\_ Assistive Technology

\_\_\_ Oral Testing \_\_\_ Calculator

\_\_\_ Interpreter \_\_\_ Stenographer

\_\_\_ Note-taker \_\_\_ Assistive Listening Device

\_\_\_ Scribe \_\_\_ Consideration for Frequent Absences

\_\_\_ Alternative Test Format: \_\_ No scantron \_\_ Enlarge Print \_\_ Rephrasing of Test Questions

**Please attach supportive documentation (medical eval, psychological eval, neuro-psychological eval, educational-psychological eval, etc.) with this form. Failure to attach supportive documentation can result in a delay of the student receiving reasonable accommodations. All documentation must be within 3 years. Handwritten notes or notes on a prescription pad are not acceptable documentation.**

**Clinician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should you have any questions or concerns please contact Joseph Williams Jr. Disability Services Coordinator by phone at 504-671-5161 or by email jwilli6@dcc.edu or by fax: 504-483-4524.

Form 1468/004 (11/19)