STUDENT ACCESSIBILITY AND RESOURCES (SAR)  
UNIVERSITY OF TEXAS AT TYLER  
DISABILITY DOCUMENTATION REQUEST FORM  

TO BE COMPLETED BY EVALUATOR  

**DO NOT USE THIS FORM FOR LEARNING DISABILITIES. PLEASE SEE LEARNING DISABILITY DOCUMENTATION GUIDELINES FOR MORE INFORMATION**  

Student’s Name: ________________________________________________________________  
Phone Number: ___________________________ Date of Birth: ___________________________  
When did/will you start attending UTT?  Semester_______________________ Year: ______________________  
UTT I.D. Number: ___________________________ UTT Email: ___________________________  

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from SAR. To consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a **qualified professional** provide current and comprehensive documentation of disability(ies). A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified mental health professional **who is not a family member of the student**.

***This form must contain ALL the requested information below to apply for accommodations through SAR. ***

1. Diagnosis(es) (use DSM-5TR for psychiatric conditions):
   ____________________________________________________________________________

2. If you have a formal evaluation, please attach it.

3. Date of Diagnosis(es): ________________ Date of Last Contact with Student: ________________

4. Provide a summary of the student’s educational, medical, and family history that may relate to disability(ies) (must demonstrate that difficulties are not the result of other conditions, cultural differences, or insufficient instruction):
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

5. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting.
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
6. List **current medication**, along with any **current side effects** that may impact academic performance:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

7. Please indicate below the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student’s educational opportunities at UTT 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: _________________________________________________________

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