Psychological Disability Verification Form

The Office of Student Access Services (SAS) provides reasonable accommodations to students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive accommodations, the documentation must show functional limitations that impact the individual in the same or a comparable academic (or residential, if applicable) setting.

SAS requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for reasonable accommodations. This form is not required, as long as the information indicated below is included in the submitted documentation.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified or licensed psychologists or members of a medical specialty.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or unclear writing will delay the eligibility review process and will necessitate follow-up contact with the student.

C. The healthcare provider should attach any reports which provide related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.

D. After completing the “Diagnostic Information” form, sign it, complete the “Provider Information” section on the last page and mail, e-mail (scan & attach), or fax it to us, using the contact information in our letterhead. The information you provide will not become part of the student’s educational records, and will be held strictly confidential, in accordance with the Family Educational Rights and Protection Act of 1974 (FERPA) laws and related regulations. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information that would be relevant to the student’s accommodation request(s).

If you have questions regarding this form, please contact the SAS office at 703-284-1538. Thank you for your assistance.

STUDENT INFORMATION
(Please Print Legibly or Type)

Name (Last, First, Middle): ________________________________________________

MU ID#: ___________________________ Date of Birth: _______________________

Status (check one):  ☐ current student  ☐ transfer student  ☐ prospective student
☐ visiting or consortium student

Cell Phone: ________________________ Alt. Phone: _________________________

MU e-mail: ___________________________@marymount.edu

DIAGNOSTIC INFORMATION
(Must be completed by a qualified, licensed professional)

1. Date of Diagnosis: _______________________________________________________

2. Date student was last seen: ______________________________________________

3. DSM-IV diagnosis:
   Axis I: ________________________________________________________________
   Axis II: ________________________________________________________________
   Axis III: ________________________________________________________________
   Axis IV: ________________________________________________________________
   Axis V (GAF Score): _______________________________________________________

4. In addition to DSM-IV criteria, how did you arrive at your diagnosis?
   ☐ Structured or unstructured interviews with the student
   ☐ Interviews with other persons
   ☐ Behavioral observations
   ☐ Developmental History
   ☐ Educational History
   ☐ Medical History
   ☐ Neuropsychological testing (dates of testing) _______________________________
   ☐ Psycho-educational testing (dates of testing) _______________________________
   ☐ Standardized or non-standardized rating scales
   ☐ Other (please specify) ___________________________________________________
5. **How would you describe the severity of the disability?**

   - [ ] mild
   - [ ] moderate
   - [ ] severe

   Please explain the severity level checked above:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. **What is the expected duration of this individual’s disability?**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7. **Major Life Activities Assessment:** Please check which of the following major life activities listed above are affected because of the impairment. Indicate severity of limitations.

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<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Don’t Know</th>
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<tr>
<td>Concentrating</td>
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<td>Organization</td>
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8. Please describe the student’s symptoms, in relation to this diagnosis

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______________________________________________________________________________

9. What specific symptoms does the student have that would affect the student’s performance, academically, socially, behaviorally, physically, and residentially?

______________________________________________________________________________

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______________________________________________________________________________

10. Describe any situations or environmental conditions that might lead to an exacerbation of the diagnosed condition(s).

______________________________________________________________________________

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______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

11. Is this student currently receiving therapy or counseling?
12. What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student’s performance, academically, socially, behaviorally, physically, and residentially?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

13. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/adjustments/services are warranted based upon the student’s functional limitations. Indicate why the accommodations are necessary.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

14. If the current treatments (i.e. medications and therapy) are successful, state the reason the above academic adjustments, auxiliary aids, and/or services are necessary.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
PROVIDER INFORMATION PAGE
(Please sign and date below. Fill-in all other fields completely using PRINT or TYPE)

Provider Signature: ________________________________ Date:__________

Provider Name (Print):________________________________________________________

Title: ______________________________________________________

License or Certification #: ____________________________________________

Address: __________________________________________________________________

__________________________________________________________________________

Phone Number: (_____ ) _____ - _________

Fax Number: (_____ ) _____ - _________

[ If available, please attach your business card here ]