Student Accessibility Services  
Medical or Psychiatric Disability Verification

Completing this form will help in determining disability eligibility and appropriate, reasonable accommodations for the student listed below. Thank you for your assistance in this matter. Please contact this office at (860) 439-5428 if you have any questions.

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA). These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

Missing information may cause a delay in our ability to evaluate the student’s request for accommodations.

To Be Completed by the Student

Student’s name: ______________________________________________________________________________________________________

Student’s e-mail: _______________________________________           Student’s phone: ____________________________________

To Be Completed by the Student’s Provider or Clinician  
(may not be related to the student)

1) Please state diagnosis (a psychiatric disability must meet criteria for a DSM-V diagnosis):
____________________________________________________________________________________________________________________________________

2) How was the diagnosis arrived at? Please check all that apply below:
   ___ Structured or unstructured interviews           ___ Medical tests           ___ Behavioral observations
   ___ Interviews with other person(s)               ___ Medical history         ___ Developmental history

3) Date of diagnosis: ______________________________

4) This student has been under a provider’s care for this issue since: __________________________________________________________

5) Date the student was last seen by you: _____________________________________________________________

6) Expected duration of impairment/disability: _____________________________________________________________

7) How often is the student required to check-in with you? _____________________________________________________________
8) What is the severity of the condition (mild, moderate, severe, etc.)? 

Check all relevant functional limitations AND explain how each will affect your patient/client in the academic environment:

<table>
<thead>
<tr>
<th>FUNCTIONAL LIMITATIONS</th>
<th>Mild</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring for oneself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performing manual tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation of a major bodily function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9) Please provide your recommendation for reasonable accommodation(s) for this student and how these accommodations will address specific functional limitations:

_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

10) Anticipated duration of need for accommodation:

__________________________________________________________________________________________________________________________

11) Please state alternatives to meet the documented need if the request cannot met:

____________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________
12) Describe the current treatment plan, medications, devices or services prescribed or used to minimize the impact of the condition:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

13) How might side effects of medications, if any, affect the student’s academic performance?

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

14) Please discuss the impact on your client's disability if the accommodation cannot be granted:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

15) Additional comments:

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

Hearing Impairments-Please attach most recent audiogram
Visual Impairments-Please attach acuity information

Provider’s Signature: ____________________________ Date ____________________________

Provider’s Name (please print) /Academic Credentials ____________________________

License/Certification # ____________________________ State ____________________________

Address __________________________________________________________________________

City, State, Zip code ____________________________

Phone ____________________________ Fax ____________________________

Please send all documentation to:
Office of Student Accessibility Services
Connecticut College
Campus Box 5264
270 Mohegan Avenue
New London, CT 06320
Fax to: (860) 439-2003
**General Documentation Guidelines**

1. Documentation must be typewritten on business letterhead from a licensed professional not related to the student who is qualified to give a psychological and/or medical diagnosis. The name, credentials and signature of the licensed professional must appear on the documentation.
2. The documentation must include all pertinent diagnoses, clearly stated and explained.
3. Information outlining testing/assessment tools must be included. Learning disability testing must include the actual standard test scores; student must be tested using measures normed on adult populations.
4. Documentation must include information on how the disability currently impacts the individual and document “how a major life activity is limited by providing a clear sense of the severity, frequency and pervasiveness of the condition(s)”.
5. All pertinent positive and negative effects of mitigating measures must be addressed. This could include a description of treatment, medications (and potential side effects) and assistive devices with estimated effectiveness of their impact on the disability.
6. Documentation should provide recommendations for accommodations for the individual and include the rationale for the recommended accommodations.

<table>
<thead>
<tr>
<th>Disability</th>
<th>Currency of Documentation</th>
<th>Accepted Evaluator</th>
<th>Elements of Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>Within 3 years</td>
<td>Psychologist, psychiatrist, neuropsychologist, and other relevantly trained medical doctor*</td>
<td>Evidence of early impairment from more than one setting; evidence of current impairment; summary of neuropsychological or psychoeducational assessments to determine the current functional limitation pertaining to an educational setting; prescribed medications, dosages and schedules; suggestions of accommodations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Requires same level of documentation as psychologist, psychiatrist and neuropsychologist.</td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorder/Asperger’s syndrome</td>
<td>Within 3 years</td>
<td>Developmental pediatrician, neurologist, psychiatrist, psychologist, neuropsychologist</td>
<td>Academic testing — standardized achievement tests, including standard scores; impact of symptoms on learning; ability to function in a residential college community; prescribed medications, dosages and schedules that may influence the learning environment.</td>
</tr>
<tr>
<td>Chronic illness and physical impairment</td>
<td>Depends on condition</td>
<td>Licensed medical professional</td>
<td>Documentation will vary based on the diagnosis, which would include conditions such as asthma, allergies, arthritis, diabetes, fibromyalgia, migraine and multiple sclerosis.</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>Depends on whether condition is static or changing</td>
<td>Otorhinolaryngologist, otologist, licensed audiologist</td>
<td>Audiological evaluation or audiogram administered by a licensed audiologist; interpretation of the functional implications; suggestions of accommodations.</td>
</tr>
<tr>
<td>Learning disability</td>
<td>Within 3 years</td>
<td>Clinical or educational psychologist, school psychologist, neuropsychologist, learning disabilities specialist</td>
<td>Assessment must be comprehensive (more than one test) based on adult measures and address intellectual functioning/aptitude, preferably the Wechsler Adult Intelligence Scale-III with standard scores; achievement — current levels in reading, math and written language (acceptable instruments include the Woodcock Johnson Psychoeducational Battery III, Wechsler Individual Achievement Test or others); and information processing utilizing subtests from the WAIS-III, WJ III or others. Individual “learning styles,” “learning differences,” “academic problems” and “test difficulty or anxiety” do not constitute a learning disability. Please refer to General Documentation Guidelines above.</td>
</tr>
<tr>
<td>Psychiatric disorder</td>
<td>Within 6 months</td>
<td>Licensed clinical psychologist, psychiatrist, psychiatric advanced practice registered nurse (APRN), licensed clinical social worker</td>
<td>Family history; discussion of dual diagnosis; current diagnosis (DSM-5) indicates the nature, frequency, severity of symptoms — diagnosis without an explicit listing of current symptoms is not sufficient; prescribed medications, dosages and schedules that may influence the learning environment; types of accommodations, including any possible side effects.</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>Depends on condition</td>
<td>Ophthalmologist</td>
<td>Ocular assessment/evaluation; suggestions on how the condition may be accommodated.</td>
</tr>
</tbody>
</table>

**Acknowledgement:** This information is based on the Disability Documentation Guidelines to Determine Eligibility for Accommodations at the Postsecondary Level developed by the Connecticut Association on Higher Education and Accessibility.

It is important to have recent and appropriate documentation because accommodations are determined based on the current impact of the condition(s) and how it affects access to academics and educational activities.

Any questions about appropriate documentation should be directed to the Director of Student Accessibility Services who can be contacted at (860) 439-5240