CERTIFICATION OF PSYCHOLOGICAL DISABILITY

The student named below has begun the process to request services with Student Accessibility Services (SAS) at Connecticut College. To determine eligibility and provide services, we require documentation of the student’s disability.

Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

RELEASE OF INFORMATION

I, (student print name) ________________________, hereby authorize the release of the following information to Student Accessibility Services (SAS) at Connecticut College for the purpose of determining my eligibility for educational accommodations.

__________________________________________         ________________            ___________
Student Signature     Camel ID#        Today’s Date
PSYCHOLOGICAL DISABILITY VERIFICATION FORM

To the certifying professional:

Please complete the form below in as much detail as possible. Email or mail it directly to Student Accessibility Services (SAS) using our contact information at the bottom of the page. The information you provide will not become part of the student’s educational records. It will be kept in the student’s file in SAS, where it will be held strictly confidential. This form may be released to the student at his/her/their request. In addition to the desired information below, please attach any other information you feel would be relevant to the student’s adjustment in the academic environment. Please contact SAS if there are any questions or concerns.

1. Student’s Name: _____________________________________________ Date: ________________________
2. What is your DSM V diagnosis for this student?
   a. Axis I: ______________________________________________
   b. Axis II: ______________________________________________
   c. Axis III: ______________________________________________
3. Date of Above Diagnosis: ______________________________________
4. Date Last Seen: ______________________________________________
5. In addition to DSM V criteria, how did you arrive at your diagnosis?
   Please check all relevant items below. Add brief notes you believe may be helpful to us as we determine which accommodations and services are appropriate for the student.
   □ Structured or unstructured interviews with the student
   □ Interviews with other persons
   □ Behavioral observations
   □ Developmental history
   □ Educational history
   □ Medical history
   □ Neuropsychological testing. Date(s) of testing: __________________________
   □ Psychoeducational testing. Date(s) of testing: __________________________
   □ Standardized or non-standardized rating scales: __________________________
   □ Other, please specify: __________________________
6. Please check which of the major life activities listed below are impacted because of the psychological diagnosis.
   Please indicate the level of limitation.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Don’t Know</th>
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</thead>
<tbody>
<tr>
<td>Concentration</td>
<td>□</td>
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<td>□</td>
<td>□</td>
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<td>Memory</td>
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<td>Sleep</td>
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<td>Eating</td>
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<tr>
<td>Life Activity</td>
<td>No Impact</td>
<td>Moderate Impact</td>
<td>Severe Impact</td>
<td>Don’t Know</td>
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<tr>
<td>Social Interactions</td>
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<td>Self-Care</td>
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<tr>
<td>Managing Internal Distractions</td>
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<td>Making &amp; Keeping Appointments</td>
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<td>Stress Management</td>
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<tr>
<td>Organization</td>
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</tbody>
</table>

7. Is the student currently taking medication(s) for these symptoms? ☐ Yes ☐ No
   If yes, describe medication(s), date(s) prescribed, effect on academic functioning and side effects?
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

Do limitations/symptoms persist even with medication? ☐ Yes ☐ No

8. How long do you anticipate the student’s academic achievement will be impacted by this disability?
   ☐ < Six Months ☐ One Year ☐ One Year +

9. Please state the student’s functional limitations based on the psychological diagnosis, specifically in a classroom or educational setting.
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

10. Please list any specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations or services are warranted based upon the student’s functional limitations. Indicate why the accommodations are necessary.
    ________________________________________________________________________________________
    ________________________________________________________________________________________
    ________________________________________________________________________________________
11. Additional Information:
   a. What other specific symptoms currently manifesting might impact the student’s academic performance?
   b. Is there anything else we should know about the student’s psychological disability?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

________________________________________
CERTIFYING PROFESSIONAL*
Professional’s Name ___________________________ Title ___________________________
Name of Practice __________________________________________________________________________________
Address _________________________________________________________________________________________
License No. _______________________________ Email _____________________________________________
Phone __________________________ Fax __________________________
Signature of Professional __________________________ Date __________________

*Qualified diagnosing professionals are licensed psychologists, psychiatrists, neurologists, clinical social workers and counselors. The diagnosing professional must have expertise in the differential diagnosis of the documented mental disorder or condition and follow established practices in the field.