CONNECTICUT COLLEGE

Student Accessibility Services

Psychological Disability Verification
Fillable Form*

The student named below has begun the process of requesting services with Student Accessibility Services (SAS) at Connecticut College. We require documentation of the student's disability to determine eligibility and provide services.

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

_____

Student Signature Camel ID # Date

Psychological Provider Form

The following information is to be completed by a medical professional only.

Please give your provider ample time to complete the information requested.

Students upload the completed form to your AIM online portal.

*Text field will be displayed either next to or under the first word of the question or tab to the next field Note: Provider signature is not fillable. The document must be printed and signed by provider prior to submission.

Psychological Disability Verification Form
To be completed by provider:

To the certifying professional:
Please complete the form below in as much detail as possible. 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 request. 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?

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
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Neuropsychological testing Dates of testing:
- ☐ Psychoeducational testing Dates of testing
- ☐ Standardized or non-standardized testing rating scales:
- ☐ Other, please specify
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history

6. Is the student currently taking medication(s) for these symptoms? Yes ☐ No ☐
If yes, do limitations/symptoms persist even with medication? Yes ☐ No ☐
Please describe medication(s), date(s) prescribed, effect on academic functioning, and side effects.

7. How long do you anticipate this disability will impact the student's academic achievement?
☐ < Six months ☐ One year ☐ One year +

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

9. Please list any specific recommendations regarding this student's academic accommodations and a rationale for why these accommodations or services are warranted based on the student's functional limitations. Indicate why the accommodations are necessary.

10. 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?

Please attach any additional information you feel would be helpful

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CERTIFYING PROFESSIONAL*

Professional's Name: Title:

Name of Practice:

Address:

Phone: Email:

License # and Issuing State:

Signature of Professional: Date:

*Qualified diagnosing professionals are licensed psychologists, psychiatrists, neurologists, clinical social 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 fields.