UNION COLLEGE
FOUNDED 1795

Tel. (518) 388-8785
Email: sas@union.edu
STUDENT ACCESSIBILITY SERVICES

Psychological/Psychiatric Disability Verification Form

The student named below has applied for academic accommodations from Student Accessibility Services (SAS) at Union College. To determine eligibility and to provide accommodations, we require documentation of the student's psychological/psychiatric disability. **This form should <u>not</u> be used to support a request for accommodations based on a diagnosis of ADHD, other health impairment, specific learning disability, or medical disability.**

Under the Americans with Disabilities Act as amended 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 accommodation. The documentation must also support the request for accommodations and academic adjustments.**

**** Pages 2-4 of this form must be completed by a medical or mental health provider who has assessed the student <u>within six months of completing this form</u>. The provider may not be related by blood or marriage to the student.****

After completing this form, please sign it and email it to us at the email address noted in the top right corner of this page. The information you provide will not become part of the student's educational records but will be kept in the student's file at SAS, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant. Please contact us if you have questions or concerns. Thank you for your assistance.

RELEASE OF INFORMATION

I, _____, hereby authorize the release of the following information to Student Accessibility Services at Union College for the purpose of determining my eligibility for academic accommodations.

Student ID #: _____ Date: _____

Signature: _____

Student Name: _____

TO BE COMPLETED BY LICENSED PROVIDER

Please list the diagnosis(es) and DSM V code(s): _____

_____

_____

_____

Date of diagnosis(es): _____

How did you diagnose the student? Please include diagnostic criteria, evaluation methods/procedures, tests/dates of administration, and any clinical observations. Please attach additional pages if necessary on your signed letterhead.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is the student currently under your care? ▢ Yes ▢ No

How frequently do you meet with the student? _____

_____

Date of last contact with student: _____

Medication prescribed: ▢ Yes ▢ No If yes, please list medications and current dosage(s): _____

_____

_____

Name of prescriber: _____

Effect of medication on academic functioning, if any: _____

_____

_____

_____

_____

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

Student Name: _____

Major Life Activities Assessment:

- *How does the diagnosis(es) impact the student? Please check which of the following major life activities listed below are impacted by the diagnosis, as well as the severity of the impact.*

Life Activity	No Impact	Minor Impact	Moderate Impact	Substantial Impact
Caring for oneself				
Sleeping				
Socializing				
Communicating with Others				
Managing Time				
Initiating or Completing Tasks				
Emotional Regulation				
Eating				
Working				
Learning				
Reading				
Writing/Spelling				
Calculating				
Memorizing				
Concentrating				
Listening				
Other:_____				

Please provide additional information on any functional impact that is noted above specific to a postsecondary academic setting.

_____
_____
_____
_____
_____
_____

How long do you anticipate the student will be impacted by this diagnosis(es)?

▢ Six months ▢ One year ▢ One year +

Student Name: _____

Has the student been hospitalized or needed more intensive care (intensive outpatient or partial hospitalization) in the past year in relation to the above diagnosis(es)?

▢ Yes ▢ No If yes, please describe the circumstances. _____

_____

_____

_____

_____

_____

Recommended accommodations for the student, based on the functional impact of diagnosis(es): _____

_____

_____

_____

_____

_____

If there is other relevant information that you feel we should know in order to better support the student, please describe below, or attach the information separately on your signed letterhead. _____

_____

_____

_____

_____

_____

Thank you for your help in providing this information. Please return this completed form to the email address on page 1, or to the student.

LICENSED PROVIDER INFORMATION

(Please complete all fields below, and sign and date.)

Provider Name and Medical Specialty:

_____

License Number: _____ Phone: _____

Address: _____

Email: _____

Signature: _____ Date: _____

Official Stamp: