



# CONNECTICUT COLLEGE

## STUDENT ACCESSIBILITY SERVICES

### 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.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Internal Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing External Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making & Keeping Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

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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.

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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.

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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?

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**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.