VERIFICATION OF PSYCHIATRIC CONDITION

To Be Completed By Appropriate Treating Clinician

Date __________________

I, the undersigned, certify that:

Name of student: ____

Date of Birth: ____

Address:____

____

Phone: (   )______________________

Has the following diagnoses/condition:

1.) Diagnosis/description of psychiatric condition; **please provide full DSM-IV CODE:**

2.) Symptoms/manifestations: (e.g., mood liability; difficulties with attention, memory, or expression)

3.) This individual's condition substantially limits him or her in a major life activity (Circle one) Yes No

If yes, what activities are significantly limited?

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____

3.) Date the diagnosis was formally established: ________________________________

4.) Current treatment(s)/therapy and prescribed medications and dosage:

5.) The medical condition or disability above is:

- ☐ Permanent/chronic
- ☐ Long term: 3-12 months
- ☐ Short term/temporary: 60-90 days
- ☐ Temporary: Less than 60 days

6.) Please use space below (and additional sheets of paper) to provide any information that will be helpful to the Disability Services Coordinator in considering the accommodations that you are recommending.
   a.) What is the likely impact on academic performance if the request is not met?
   b.) What is the likely impact on social development if the request is not met?
   c.) Is the request an integral component of a treatment plan for condition on question?

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7.) Please list any academic, housing, or other accommodations you recommend:

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All recommendations are considered. Decisions are made based on the nature of the disability, reasonableness of the request, academic integrity, and available housing.

Signature Date

Name (Please Print)

Title

Name of Agency/Practice

( ) ( )

Phone number Fax Number

Street Address

City/State/Zip

All documentation submitted for consideration to the Services for Students with Disabilities Office is confidential. When submitting documentation, **please include a copy of any available releases** allowing communication between the Disability Services Counselor and the diagnostician. Documentation can be mailed to:

Jefferson College of Health Sciences
Attn: Disability Services Counselor
101Elm Ave., SE.
Roanoke, VA 24013
Fax: (540) 985-8001
Please include a fax cover sheet for confidentially purposes