CONNECTICUT COLLEGE

Student Accessibility Services

Medical or Psychiatric Disability Verification

Completing this form will help in determining disability eligibility and appropriate, reasonable accommodations for the student listed below. Thank you for your assistance in this matter. Please contact this office at (860) 439-5428 if you have any questions.

> To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA). These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

Missing information may cause a delay in our ability to evaluate the student's request for accommodations.

To Be Completed by the Student

Student's name: ____

Student's e-mail: _______________________________________ Student's phone: _____________________

To Be Completed by the Student's Provider or Clinician (may not be related to the student)

1) Please state diagnosis using the diagnostic categorization of the ICD or DSM-5:
You must state the specific diagnosis: terms such as "suggest" or "indication of" are not acceptable

2 a) How was the diagnosis arrived at? Please check all that apply below:

___ Structured or unstructured interviews with patient/client ___ Medical tests*

___ Behavioral observations ___ Interviews with other person(s) ___ Medical history ___ Developmental history

*List tests & date of each:

b) Explain more fully what evidence was used to support the diagnosis(es). Provide a copy of test results.
(attach additional pages if necessary)

3) **Date of diagnosis: ____**

4) **This student has been under a provider's care for this issue since: ____________________________________**

5) Date the student was last seen by you: ____

6) Expected duration of impairment/disability: ____

7) How often is the student required to check-in with you? ____

8) a. What is the severity of the condition (mild, moderate, severe, etc.)? __________________________________

b. Check all relevant functional limitations AND in part C explain how each will affect your patient/client in the academic environment:

FUNCTIONAL LIMITATIONS	MILD	MODERATE	SUBSTANTIAL	COMMENTS
Caring for oneself				
Performing manual tasks				
Seeing				
Hearing				
Breathing				
Sleeping				
Eating				
Standing				
Lifting				
Bending				
Walking				
Speaking				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Working				
Operation of major bodily function				
Other				

c) Based on your selections in the chart <u>explain</u> how the major life activity is limited by the student's condition:
(this is not where you recommend accommodations –see question 9)

9) Please provide your recommendation for reasonable accommodation(s) for this student and <u>how these accommodations will address specific functional limitations:</u>

10) Anticipated duration of need for accommodation:

11) Please state alternatives to meet the documented need if the request cannot be met:

12) Describe the current treatment plan, medications, devices or services prescribed or used to minimize the impact of the condition:

13) How might side effects of medications, if any, affect the student's academic performance?

14) Please discuss the impact on your client's disability if the accommodation cannot be granted:

15) Additional comments:

Provider's Signature: ____ Date _____________

Provider'Name____

Academic Credential's License/Certification #____

Address____

City, State, Zip Code____

Office# ____Fax #_______________________________________

Student upload the completed form to AIM