STUDENTS: DO NOT FILL OUT THIS FORM **FORM B**

FORM B • VERIFICATION OF PSYCHIATRIC/PSYCHOLOGICAL DISORDERS

The information provided below will assist the Disability Services staff members in collaborating with the student to determine appropriate academic accommodations. Documentation serves as a foundation that legitimizes a student's request for accommodations.

Please complete this form in its entirety. If not complete, we reserve the right to reject the documentation which will result in a delay of accommodation approval.

A diagnosis by a licensed mental health professional (includes licensed clinical social workers, licensed professional counselors, psychologists, psychiatrists and neurologists) is required. This professional must be an impartial individual who is not a family member of the student. The name and contact information for the professional must be clearly stated. All questions must be answered to provide accommodations to the student.

Student Name ______________________________ Date of Birth ______________

A. Please respond to the following items regarding the student named above. (Please type or print)

1. What is the student's DSM diagnosis?

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   a. State the student's current symptoms that meet the criteria for this diagnosis.

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   b. State the age of onset of symptoms described by DSM.

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   c. What is the severity of the condition?

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   d. State the frequency of your appointments with this student and the date of your last contact.

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3. List and describe measures and instruments used to support the Psychiatric/Psychological diagnosis. Reports may include formal instruments, medical examinations, structured interview protocols, performance observation and unstructured interviews. If results from informal or non-standardized methods of evaluation are reported, a clear explanation of their role and significance in the diagnostic process should be included.

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** ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning. •*

4. Describe the symptoms related to the student's condition that causes significant impairment in a major life activity.

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5. List the student's current medication(s), dosages, frequency, and adverse side effects.

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6. Does the student have a disability* as a result of his/her condition that warrants accommodations? ☐ Yes ☐ No
(Check "yes" if the student's condition requires accommodations.)

7. If yes, please state specific recommendations regarding accommodations for this student and a rationale as to why these accommodations are warranted based upon the student's functional limitations. Indicate why the accommodations you recommend are necessary.

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B. Provider Contact Information. Please attach cognitive and achievement diagnostic reports including standardized testing scores.

PROVIDER NAME AND TITLE

PROVIDER SIGNATURE | DATE

PROVIDER LICENSE NUMBER | ISSUING STATE

PROVIDER ADDRESS | STATE | ZIP CODE

PROVIDER TELEPHONE | PROVIDER FAX NUMBER

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