PSYCHOLOGICAL DISABILITY VERIFICATION FORM

I. Student Information:

Name: _____ Student ID#: _____

Address: _____

Phone: _____ Date of Birth: _____

I request and authorize the release of the information provided on this Disability Verification Form to the Disability Services Office at Wharton County Junior College.

Student Signature: _____ Date: _____

The following information **MUST** be:

▪ Completed by a qualified professional, including Licensed Psychologist, Counselor, Psychiatrist, Physician. The diagnosing professional must not be related to the student.

▪ Completed as clearly and thoroughly, as possible. Incomplete responses may not provide sufficient information in order for this form to stand as the sole form of documentation to support reasonable academic accommodations.

▪ Submitted to the Disability Services office at WCJC. All documentation is considered confidential and released to the student, upon request.

II. Diagnosis (DSM-5 or ICD 10):

Name	Code (DSM-5)	Code (ICD-10)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Date diagnosed: _____

Date of last clinical contact with student: _____

Severity of symptoms (current):

☐Mild ☐Moderate ☐Severe

Approximate onset of condition:

☐Child (age:) ☐Adolescent (age:) ☐Adult (age:) ☐Unknown

What sources of information did you consider in making this determination/diagnosis?

Please check all relevant items below, adding any notes that you think might be helpful to us as we determine accommodations.

☐Clinical Interview (structured or unstructured)

☐Developmental History/Interview(s) with other persons (e.g., parent, teacher, therapist)

☐Behavioral Observation(s)

☐Psychoeducational Assessment (attach document)

☐Psychological Assessment (attach document)

☐Other (please specify): _____

III. Impact of Disability:

Does this condition interfere with one or more of the following major life activities?

☐caring for self	☐performing manual tasks	☐walking
☐seeing	☐hearing	☐speaking
☐breathing	☐learning	☐working
☐eating	☐sleeping	☐standing
☐lifting	☐bending	☐reading
☐concentrating	☐thinking	☐communicating
☐other:	☐other:	☐other:

Describe the functional limitations and any other factors that may impact the student in an educational setting (e.g., easily distracted, poor concentration, difficulty focusing for extended periods of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations):

IV. Certification by Qualified Professional:

Name: _____ Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Date: _____ License Number: _____