PSYCHOLOGICAL DISABILITY VERIFICATION FORM

SECTION I - To be completed by the student:

Name: _____ Student ID#:_____

Address: _____

Phone: _____ Date of Birth: _____

Physician's Name: _____

I authorize the release of the information requested on this Medical Disability Verification Form to WCJC Disability Services Office.

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.

SECTION II – To be completed by the physician:

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 onsets of condition (check one and include age):

☐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): _____

Impact of Disability:

How do these diagnoses affect the patient's ability to access the learning environment?

_____

_____

Certification by Qualified Professional:

Name: _____

Signature: _____

Address: _____

Date: _____ License Number: _____