Verification of Psychological Disability For Students with Disabilities

Pitzer College
1050 North Mills Ave.
Claremont, CA 91711-3941
Phone: 909-621-8241

A patient/client of yours has requested disability-related services from Pitzer College. Legal protection and eligibility for such services is based on an individual providing sufficient information to conclude that the student has an impairment that substantially limits one or more major life activities. Documentation must be provided by a qualified professional, preferably a psychiatrist, licensed clinical psychologist, neurologist, clinical social worker or marriage and family therapist. As this student's treating specialist, you are asked to provide the following information to allow Pitzer College to consider this student's service requests(s). You may also want to attach additional information that supports the diagnosis.

Student Name _____

1. **DSM-IV Diagnosis:**

   AXIS I: _____

   AXIS II: _____

   AXIS III: _____

   AXIS IV: _____

   AXIS V: Current GAF _____ Highest GAF in past year _____

2. **Date of diagnosis:** _____ Last contact with student: _____

3. **Will you continue to see the student?** No _____ Yes _____

4. **What assessment instruments were used to make the diagnosis?**

   - ☐ Structured or unstructured interviews and pertinent history
   - ☐ Behavioral observations
   - ☐ Psychiatric consultation
   - ☐ Standardized or unstandardized rating scales
   - ☐ Interview with other persons
   - ☐ Other (Please specify)

5. **Is this student currently taking medication? No _____ Yes _____**

   a. List medication(s) and date(s) prescribed:

   b. Does this medication and/or side effects have an effect on academic functioning? No _____ Yes _____
   If yes, please describe:

   c. Do limitations/symptoms persist even with medication?

6. **What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability?**

   - ☐ Temporary – Date disability will end: _____ (Accommodations not necessary after this date.)
   - ☐ 6 months
   - ☐ 1 year
   - ☐ More than 1 year

7. **Indicate the major symptoms of the disorder and level of severity currently experienced by the student.**

Symptom	Mild	Moderate	Severe

8. **Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.**

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating				
Memory				
Sleeping				
Eating				
Social Interactions				
Self-care				
Managing Internal Distractions				
Managing External Distractions				
Timely Submission of Assignments				
Attending Class Regularly & on Time				
Making & Keeping Appointments				
Stress Management				
Organization				
Test Taking				
Other				

9. **What are your specific recommendations for this student regarding academic accommodations in a college environment? Examples of accommodations include extended time on tests, testing in a distraction-reduced environment, note taker, books on CD, etc.**

Clinician Name *in print* _____ License _____

Professional Degree _____

Address _____

_____

e-mail _____ phone# _____

Signature _____ **Date** _____