

Verification Form for Psychiatric Disabilities

Students requesting support services under laws pertaining to non-discrimination for individuals with disabilities such as the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 are required to submit documentation to verify their eligibility for services and accommodations. This documentation must indicate evidence that the disability substantially limits a major life activity such as learning. The provision of "all reasonable accommodations" is based on the current impact of the disability on academic performance. Thorough documentation is needed to help determine the reasonable and appropriate accommodations that the student is qualified to receive. Therefore, it is in the student's best interest to provide recent and appropriate documentation.

The Center for Learning and Adaptive Student Services (CLASS) at Augsburg College strives to ensure that qualified students with psychiatric disabilities are accommodated and, if possible, to see that these accommodations do not jeopardize successful therapeutic interventions. It should be noted that academic accommodations are intended to ensure access to educational opportunities for students with disabilities. The mandate to provide reasonable accommodations does not extend to adjustments that would "fundamentally alter" the nature of the course, course components, or course requirements.

The student named below is requesting an accommodation due to their psychiatric disability. So as to ensure that this accommodation request be considered, CLASS requires that the following form be completed by a qualified professional who has first-hand knowledge of the student's condition and is an impartial individual not related to the student.

Student Information (This section is to be completed by the student)

Last Name _____ First _____ MI

Address

City _____ State _____ Zip Code

Date of Birth ____/____/____ Phone

Professional Information (This section is to be completed by a qualified Professional)

Date of Completion of Form ___/___/____

Name of Certifying Professional

Address

City _____ State _____ Zip Code

Phone _____ Fax

Professional Title

License/Certification Number and Issuing State

Date of Initial Contact with Student _____/_____/_____

Date of Last Contact with Student _____/_____/_____

Multi-Axial DSM-IV Diagnosis:

Diagnoses

Comments

Axis I

Axis II

Axis III

Axis IV

Axis V

Date of Diagnosis _____/_____/_____

Basis on which the diagnosis was made.

If psychological tests were used, please include all scores used to support the diagnosis.

If the diagnosis includes a phobic response to exams, does this problem limit the student's demonstration of their knowledge of the class material on a non-accommodated exam?

_____ Yes _____ No

Explanation

Medications

Current medication including dosage and side effects

Long term medication plan

Current compliance with medication plan

Prognosis for medication plan (Include likelihood of improvement or deterioration and within what approximate timeframe.)

Therapeutic Interventions

Planned therapeutic interventions

Current compliance with therapeutic interventions

Prognosis for therapeutic interventions (Include likelihood of improvement or deterioration and within what approximate timeframe.)

Does this person currently pose a threat to him/herself or others? If so, please specify.

History of hospitalization

Impact of Condition on Educational Success

Please identify the specific academic abilities or functions that are compromised by the disorder. Indicate severity of these limitations

Please specify the impact of the disorder and prescribed medications upon exams and other classroom activities.

Suggested Accommodations

NOTE: *Final determination of appropriate accommodations will be determined by CLASS in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation must be accompanied by an explanation of its relevance to the diagnosed disability.*

Extended time to complete exams _____ Yes _____ No
Why?

Quiet room in which to take exams _____ Yes _____ No
Why?

Other accommodations (Please specify) _____ Yes _____ No
Why?

Thank you for your assistance in completing this form.

If you have any questions regarding the nature of this information needed for students with psychiatric impairments, please call the Center for Learning and Adaptive Student Services at (612) 330-1053, Mon. through Fri. from 8:00 A.M. to 5:00 P.M. This form should be returned to Augsburg College, 2211 Riverside Ave., CB # 57, Minneapolis, MN 55454.

This document may not be released without written permission from the student or by order of a court. It will be destroyed three years after the student is no longer enrolled. The student will have access to this document but you may specify that this access be given only when a person qualified to explain the document is available.