Southeast Arkansas College
1900 Hazel
Office of Disability Services
Pine Bluff, Arkansas 71603
Phone/Fax: 870-850-2183

Psychiatric Disability Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Title II of the Americans with Disabilities Act (ADA) OF 1990. The ADA defines a disability as a physical or mental impairment has substantially limits one or more major life activities. "Major life activities" include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others. For a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Southeast Arkansas College (SEARK) generally requires documentation prepared within the last three (3) years. SEARK reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified practitioner. These persons are generally trained, certified or licensed psychologist, psychiatrists, licensed counselors, or other mental health professionals.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related information; copies of that report can be submitted for documentation instead of this form.
- **After completing this form, sign it, complete the healthcare provider information section on the last page and mail or fax it to the ODS at the address provided above on this form.** The information that you provide will NOT become part of the student's educational record, but it will be kept with the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

First name_____ Middle_____ Last_____

Date of birth_____ Last four digits of SSN_____

Status (Check one) __current student __transfer student __ prospective student

Cell phone (____) _____-_____ Local phone (____) _____-_____

Address_____

_____

Diagnostic Information

Please provide the following information:

1. Date of Diagnosis_____

2. Date of Last Contact with Student: _____

3. DSM-V Diagnosis(es):

_____

_____

_____

_____

* DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The DSM-V was published on May 18,2013 and is included here. The DSM-V supersedes the SMV-IV which was published in 2000.

4. How did you arrive at your diagnosis?

__ Structured or unstructured interviews with the student
__ Interviews with other persons
__ Behavioural observations
__ Developmental history
__ Educational history
__ Medical history
__ Neuro-psychological testing Date(s) of testing? _____
__ Psycho-education testing Date(s) of testing? _____
__ Standardized or non-standardized rating scales _____

5. What is the severity of the condition? Please check one:

__ Mild ___ Moderate ___ Severe

Explain severity:

_____

_____

_____

_____

6. Is the student currently receiving therapy or counselling?

____ Yes ___ No ___ Not Sure

7. What specific symptoms does the student have that might affect his/her academic performance?

_____
_____
_____
_____

8. What is the expected duration of this disability?

_____
_____
_____

9. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary. These recommendations must be specifically related to the diagnosis.

_____
_____
_____
_____
_____
_____
_____

Health Care Provider's Signature Information

Print, sign, and date below and fill in the other fields completely. *Please print or type*

Provider's name(Print)_____

Provider's signature: _____ Date_____

Title: _____

License or Certification #_____

Address:

_____

_____

_____

Phone number (___) _____-_____ Fax number (___) _____-_____