Psychological Disability Verification Form

To Evaluator: To qualify for support services from the San José State University Accessible Education Center, a student must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive. In most cases, documentation should be based on a comprehensive diagnostic/clinical evaluation. The report must include a specific diagnosis based on the DSM-IV. Evaluators are encouraged to cite the specific objective measures used to help substantiate the diagnosis. The evaluator should use direct language in the diagnosis of a psychiatric disorder, avoiding the use of such nonspecific terms as “suggests”, “has problems with”, or “may have emotional problems.”

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,” as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For general questions pertaining to this form, or to obtain clarification about the information requested, please contact a AEC counselor at (408) 924-6000.

Name: ________________________________________________________________  
(Last, First M.I.)

Diagnosis: _____________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

DSM-IV: ______________________________________________________________
- Axis I
- Axis II
- Axis III
- Axis IV
- Axis V

Date of Diagnosis: _____________________________________________________
Duration (check one):  □ Long-term  □ Permanent

If not permanent, how long will the impairment likely last?  ____________________________________________

(specify dates)

Does the impairment affect a major life activity?:  □ Yes  □ No

If yes, what major life activity(ies) is/are affected?

□ Walking  □ Communicating  □ Lifting  □ Standing

□ Speaking  □ Learning  □ Sleeping  □ Operation of major bodily functions

□ Breathing  □ Performing manual tasks (including household chores, bathing, brushing teeth)  □ Working  □ (including functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.)

□ Hearing  □ Concentrating  □ Reproduction  □

□ Seeing  □ Caring for oneself  □ Sexual Functions  □

□ Thinking  □ Other, please describe:

□ Sitting  □ Communicating  □ Eating  □

□ Reaching  □ Learning  □ Reading  □

□ Interacting w/others  □ Performing manual tasks (including household chores, bathing, brushing teeth)  □ Running  □

□ Other, please describe:

________________________________________________________________________

________________________________________________________________________

Is the patient/client limited in one or more of these major life activities?  □ Yes  □ No

Description of current functional limitations in the academic environment as well as across other settings:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Medication(s) prescribed:  __________________________________________________________

Quantity or dosage:  _______________________________________________________________
Anticipated medication side effects that impact the individual in an academic setting.

Relevant information regarding current treatment.

**Specific Request for Accommodations with Accompanying Rationale**

The evaluator must describe the current impact of the diagnosed psychiatric disorder on a specific life activity as well as the degree of impact on the individual. A relationship must be established between the requested accommodations and the functional limitations of the individual that are relevant to the academic setting.

For example, test anxiety, in and of itself is not a sufficient diagnosis to support requests for an accommodation. Given that many individuals may perceive they might benefit from extended time in testing situations, evaluators must provide a specific rationale and justification for this accommodation.
Psychoeducational, neuropsychological or behavioral assessments are often necessary to support the need for accommodations based on the potential for psychiatric disorders to interfere with cognitive performance.

List assessments used:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If patient is following a treatment plan, please send a copy. For general questions pertaining information requested, please contact the Accessible Education Center at 408-924-6000.

Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.

Name: ________________________________ (Last, First M.I.)

Medical Facility: ________________________________

Address: __________________________________________

City: _____________________________ State: _____ Zip: ______________

License Number: ________________________________

Signature: ________________________________ Date: ______________