

Disability Services
Psychological Disability Verification Form

Student Section (Please type or print)

Name _____ Student ID # _____ Phone _____

Local Address (Street) _____ (City) _____ CO (Zip Code) _____

I authorize _____ to release information pertinent to my
(physician/therapist)
psychological condition to Disability Services at the University of Colorado at Boulder.

Student Signature _____ Date _____

M.D./Therapist Section (Please type or print):

**Note to Evaluators: Student eligibility for accommodations is based on the completeness of your answers.
This form may NOT be used for LD or ADD evaluations.**

Number of sessions with this student? _____ Date you first saw student _____ Today's date _____

Summary of presenting symptoms _____

DSM-IV Diagnosis _____ Date of Diagnosis _____

Axis I Descriptor _____ Code _____

Axis II Descriptor _____ Code _____

Axis III Descriptor _____ Code _____

Axis IV Descriptor _____ Code _____

Axis V Descriptor _____ Code _____

Note: Not all conditions listed in DSM-IV are disabilities or even impairments for the purposes of Section 504/ADA. Therefore, a diagnosis does not in and of itself meet the definition of a disability necessitating reasonable accommodations under these laws. In order to assist this office in determining a disabling condition in line with Section 504/ADA and DS policies, please address the remaining items.

How did you determine the student's diagnosis? (Circle all applicable measures and respond accordingly)

clinical interview clinical inventories other instruments (list) _____

Please list all current medications prescribed to the student _____

Does medication mitigate the student's symptoms? (Circle all applicable responses)

completely partially not mitigated

Is the student compliant in taking prescribed medication? (Y/N) _____

Any side effects that impact academic functioning? _____

Describe how the disability presents a functional limitation to a major life activity _____

How substantial are the current limitations compared to the average person in the general population?

mild moderate severe

List ways the student's learning is impacted, specific to the post-secondary environment (e.g. difficulty with concentration, slow processing speed, phobic reactions, anxiety/avoidance, stress tolerance, etc.)

The student's condition is (circle one): stable improving worsening cyclically variable

Will the student's class attendance, participation and/or responsiveness to deadlines and/or exams be impacted? _____ Explain. _____

Does the student's current course load have an impact? (12 credit hours is the minimum for full-time status.) _____ Explain. _____

Please offer any suggestions for accommodations and include your rationale. _____

When would you recommend that the student's condition to be re-evaluated? _____

Certifying Professional:

Name _____ Credentials _____

Address _____

Phone _____

License/Certification number and state where license was issued _____

Signature _____ Date _____

If you are an intern, please provide the following:

Supervisor's Name (Print) _____ Supervisor's Signature _____

Supervisor's Credentials, and License/Certification number and state where license was issued _____