



DIVISION OF
STUDENT AFFAIRS
 COUNSELING CENTER

Accessibility and Disability Service
 0106 Shoemaker Building
 4281 Chapel Lane
 College Park, Maryland 20742
 301.314.7682 TEL
 301.405.0813 FAX

Verification of Psychological Disability for Accommodations

The student named below has applied for accommodations from the Accessibility and Disability Service (ADS) at the University of Maryland College Park. In order to determine eligibility and to provide any requested accommodations, we require documentation of the student's psychological disability.

Under the Americans with Disabilities Act (Amendments Act) of 1990(2008) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

- * An assessment of a psychological disability must be relevant and appropriate to the diagnosis. It is in the client's best interest to submit documentation that is current when registering (preferably within the last six [6] months).
 - When appropriate, some clients may be asked to provide periodic updates.
- * The medical provider completing this evaluation cannot be a relative of the student or a close friend.
- * If the student's diagnosis is ADHD, please refer to the ADHD verification form, which can be found on the ADS website.

After completing this form, please mail or fax it to us. The information you provide will **not** become part of the student's education records, but will be kept in the student's file at ADS, where it will be held strictly confidential. However, this form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

Mr. Ms. Student Name (print)

Student Date of Birth

Student UID#

Student Email Address

Student Contact Number

Student Signature

Student's Gender: Male Female Trans/male Trans/female

Gender queer/non-conforming Different identity (Please state):

Student's Name:

Today's Date:

Date of initial Diagnosis:

Date Student was Last Seen: _____

DSM-5 Diagnosis(es):

1. In addition to DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items below, ***adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.***

- Structured or unstructured interviews with the person himself or herself

- Interviews with other persons

- Behavioral observations

- Developmental History

- Educational history

- Medical history

- Testing: (check all that apply)
 - Neuro-psychological testing. Date(s) of testing? (Attach copy of report)
 - Educational Testing. Date(s) of testing? (Attach copy of report)
 - Psychological Testing. Date(s) of testing? (Attach copy of report)

- Other (Please specify).

Student's Name:

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

Life Activity	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Social Interactions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Managing internal distractions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO Impact	Moderate Impact	Substantial Impact	Don't Know

Timely submission of assignments.	<input type="checkbox"/>			
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Attending class regularly and on time	<input type="checkbox"/>	<input type="checkbox"/>		
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Making and keeping appointments.	<input type="checkbox"/>			
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Stress management	<input type="checkbox"/>	<input type="checkbox"/>		
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Organization.	<input type="checkbox"/>			

3. What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

4. What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

5. Is there anything else you think we should know about the student's psychological disability?

Student's Name:

6. Please indicate the **academic accommodations** needed based on medical necessity (e.g. note takers, extended time for tests, large print etc.).

Recommended Accommodation	Justification

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

PROVIDER'S PROFESSIONAL INFORMATION*

PRINT -

Name/Degree/Field:

Signature:

Date:

License Number:

Address:

Telephone:

Fax:

The provider completing the evaluation cannot be a relative of the student; a friend of the student's family, a primary care provider or general practice physician.

****Qualified diagnosing professionals are licensed psychologists, psychiatrists, neurologists, clinical social workers, marriage and family therapists, and in some instances general practice physicians. The diagnosing professional must have expertise in the differential diagnosis of the documented mental disorder or condition and follow established practices in the field.***

*** From: University of California, Berkeley - Disabled Students' Program Certification of Psychological Disability, v. 2/02 ***Rev. 04.28.14