

## **Psychological Disability VERIFICATION FORM**

Each student requesting accommodations through the office of Disability Support Services is required to submit documentation to verify eligibility under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Amendments Act (2008). As defined by Section 504 and the ADAAA, an individual with a disability is a person who has a physical or mental impairment which substantially limits a major life activity. Academic adjustments and other accommodations are implemented to provide equal access to college programs and services.

In order to determine eligibility, a qualified professional must certify that the student has been diagnosed with a disability and provide evidence that it represents a substantial impact to a major life activity (e.g., caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, etc.). It is important to understand that a diagnosis in and of itself does not substantiate a disability. In other words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. DSS requests documentation of a disability for the purpose of establishing disability status, understanding how the disability may impact a student, and providing adequate information on the functional impact of the disability so that effective reasonable accommodations can be determined. Reasonable accommodations are individually determined based upon the information provided by the student in the intake interview and the functional impact of the condition as evidenced by supporting documentation. Prior history of having received an accommodation does not, in and of itself, warrant or guarantee its continued provision. An Individualized Education Plan (IEP) or 504 plan is almost never sufficient documentation of a disability at the post-secondary level.

This documentation form was developed as an alternative to a traditional diagnostic report. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the DSS website (<http://www.shu.edu/offices/disability-support-services/forms.cfm>) in order to view documentation guidelines. DSS expects the following in regard to this documentation form:

- The form will be completed with as much detail as possible, as a partially completed form or limited responses may hinder the eligibility process.
- The diagnosis was derived through a formal assessment.
- The assessment information must be current.
- The form is being completed by an appropriate professional, with training and expertise related to the particular psychological condition identified, such as a psychologist, psychiatrist, or certified social worker. The professional may not be a relative of this student.

## Disability Verification Form for Students with Psychological Disability

Student's Name: \_\_\_\_\_

Date of first contact with student: \_\_\_\_\_ Date of last contact with student: \_\_\_\_\_

Date(s) current psychological assessment completed: \_\_\_\_\_

Frequency of appointments with student (e.g., once a week, twice a month): \_\_\_\_\_

What is the DSM-IV diagnosis for this student?

Axis I: \_\_\_\_\_ Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_ Axis IV: \_\_\_\_\_

Axis V (GAF score): \_\_\_\_\_

How long has the student had this diagnosis/condition? \_\_\_\_\_

What is the severity of the condition?    \_\_\_ Mild        \_\_\_ Moderate        \_\_\_ Severe

Explain the severity indicated above: \_\_\_\_\_

\_\_\_\_\_

What is the expected duration?    \_\_\_ Chronic        \_\_\_ Episodic        \_\_\_ Short-term

Explain the duration indicated above: \_\_\_\_\_

\_\_\_\_\_

Provide information regarding the impact, if any, of the condition on a specific major life activity (e.g., learning, eating, walking, interacting with others, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any particular procedures used to establish diagnosis that you feel may be useful to us in determining appropriate academic accommodations or services: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

State the student's functional limitations from the disorder specifically in a classroom or educational setting:

\_\_\_\_\_

\_\_\_\_\_

List the student's current medication(s), including dosage, frequency, and adverse side effects (if applicable):

\_\_\_\_\_

\_\_\_\_\_

Are there significant limitations to the student's functioning directly related to the prescribed medications?

Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for reasonable accommodations that you believe will help equalize the student's ability to access the SHU's educational program along with rationale for each): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional information you believe would be helpful in determining the nature and severity of this student's disability, and any additional recommendations that may assist DSS in determining appropriate accommodations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### **Certifying Professional**

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Area of Specialty

\_\_\_\_\_  
License Number

\_\_\_\_\_  
State of Licensure

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
Signature of Certifying Professional

\_\_\_\_\_  
Date

**Please Return To:**  
Disability Support Services  
Seton Hall University  
400 South Orange Avenue  
Duffy Hall, Room 67  
South Orange, NJ 07079  
(973) 313-6003 (phone)  
(973) 761-9185 (fax)  
dss@shu.edu