



Fort Scott Community College
Office of Accessibility Services
2108 S Horton St
Fort Scott, Kansas 66701
Phone 620-223-2700 ext. 3570 Fax 620-223-4927

Psychiatric Disability Verification Form

The Office of Accessibility Services 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 Office of Accessibility Services requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Fort Scott Community College (FSCC) generally requires documentation prepared within the last three (3) years. FSCC 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 Office of Accessibility Services 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 in Accessibility Services, where it will be held strictly confidential.

STUDENT INFORMATION

First name _____ Middle _____ Last _____

Date of birth _____ Last four digits of SSN _____

Cell phone (____) _____ - _____ Home 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):

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 (____) _____ - _____