Disability Verification: Psychiatric Disabilities

Student Name:_____ **Birthdate:** _____

Waiver: I am requesting academic accommodations through Office of Student Accessibility Services (OSAS) at the University of Southern California. The University requires current and comprehensive documentation of my Psychiatric Disability as one of the criteria used to evaluate my eligibility for disability-related accommodations and services.

In order to provide the required documentation, I give my permission for you to complete this form on my behalf, and return it as soon as possible to me, or directly to OSAS by fax (213-740-8216) or email (sasfrntd@usc.edu).

Additionally, I authorize staff at OSAS to contact you if clarification about the information you provide is needed.

Student Signature:_____ Date: _____

Health Care Provider Name: _____

Title:_____

Specialty:_____

Phone:_____

Organization & Address: _____

_____

This Verification form should be completed as thoroughly as possible by a qualified mental health or medical professional, licensed with their state to conduct mental health-related assessment. Relatives of the student are not appropriate evaluators, even if otherwise qualified.

USC uses a multi-source process to determine student's eligibility for disability-related accommodations, including student self-report, history of accommodations (when it exists), diagnostic information and outcomes, and clinician observation. Information about how this individual student is impacted by his/her disability is carefully considered as part of the process of determining reasonable accommodations.

We appreciate your thorough and thoughtful response to the questions on this form. If you have questions about this form or how the information is used, **we invite you to contact us at 213-740-0776.**

The remainder of this form should be completed and then signed and dated by the Healthcare Professional listed on page 1.

Please note: If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

Student Information:

Student (Client) Name: _____

Date of birth: _____ USC ID#: _____

Diagnostic Information

1. Please list the diagnosis/es and the relevant DSM-5 or ICD-10 codes.

2. Severity of the diagnosis/es: ☐ *acute* ☐ *episodic* ☐ *chronic* ☐ *remission*

3. Prognosis: How long do you anticipate this student's academic performance will be impaired by her/his disability?

4. Original date of diagnosis/es: _____

5. What, if any, other diagnoses are co-existing that may compound the impact of the diagnosis?

6. Are there any differential diagnoses which are still to be ruled-out?

7. Contact with student:
   - Date of first contact with student (mm/dd/yyyy): _____
   - Date of most recent contact with student (mm/dd/yyyy): _____
   - Please describe the frequency of your contact with this student/client:

   - Re-evaluation recommended in: _____

8. What information was collected to arrive at the diagnosis?
(*Please attach/fax diagnostic report of assessment(s) if available.*)

- ☐ Neuropsychological or Psycho-educational testing dates:_____
- ☐ Behavioral Observations
- ☐ Rating Scales
- ☐ DSM-5 criteria
- ☐ ICD-10 criteria
- ☐ Developmental History
- ☐ Medical History
- ☐ Structured Interview with Student
- ☐ Structured Interview with Others (pare teachers, significant others)

9. Please describe any pertinent history about this student/client:

Functional Limitation Information

According to the ADAAA (2008), ***disability*** is defined as **an impairment that substantially limits one or more major life activities.** Major life activities include, but are not limited to, those listed in the chart below. Accommodations for this student/client will be determined based on this legal guideline. In order to provide a thorough picture of the functional limitations experienced by your student/client, please take time to indicate the frequency/duration as well as the severity of each item below. *Please include copies of assessment instruments, if they exist, that provide evidence of the functional limitations.*

10. Please rate the frequency/duration and severity (using "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a post-secondary setting.

Please include copies of assessment instruments, if they exist, that provide evidence of the functional limitations.

Major Life Activity	**Frequency/ Duration 0-4 scale***	**Severity**			
		Mild	**Moderate**	**Severe**	**Unknown or N/A**
Initiating Activities					
Concentration					
Following Directions					
Memorization					

Persistence					
Processing Speed					
Organizational Skills					
Major Life Activity	**Frequency/ Duration 0-4 scale***	**Severity**			
		Mild	**Moderate**	**Severe**	**Unknown or N/A**
Sustained Reading					
Sustained Writing					
Problem Solving					
Listening					
Sitting					
Speaking					
Interacting with Others					
Sleeping					
Hygiene routine					
Eating					
Other: please specify					
Other:					

**Frequency/Duration Scale: 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic*

11. Does this condition impact the student in the University residential setting? If so, please describe.

12. The student displays the following additional symptoms:

13. Please describe the current treatment plan for this student/client, including medication, counseling, coaching, etc. Please address any side effects/limitations of the medications for this student that could impact him/her in the University setting.

14. Other relevant information:

Accommodation Information

A diagnosis does not, in and of itself, qualify a student for accommodations under the ADAAA. Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any functional limitation(s) related to the condition. Accommodations are meant to allow for equal access to academic and university life for students with disabilities; they do not guarantee student success.

Please indicate your recommendations for accommodations within the post-secondary environment, as supported by the reported functional limitations and their impact on this student.

Accommodation:
Rationale:

Accommodation:
Rationale:

Accommodation:
Rationale:

Clinician Information (to be completed and signed the licensed clinician who completed this form)

Date: _____

Clinician Name (print): _____

Clinician Signature: _____

License Type and #: _____

Clinic or Organization: _____

Address: _____

Phone: _____ Email: _____