Office of Accessibility Services

Office of Accessibility Services • PO Drawer 7007• Greenville, North Carolina 27835-7007
Phone (252) 493-7595 • Fax (252) 321-4345 • Everett Building, Room 114

DISABILITY VERIFICATION FOR PSYCHOLOGICAL/PSYCHIATRIC CONDITION

I, (STUDENT) ______________________________ , hereby authorize the release of the following information for the purpose of determining my eligibility for academic accommodation, as based on the federal guidelines for the definition of a disability. If you have any questions, please contact **Office of Accessibility Services**, Pitt Community College PO Drawer 7007, Greenville, NC 27835-7007. **PHONE**: 252-493-7595 **FAX**: 252-321-4246

__________ ______________________________ __________________________
Date Signature of Student Date of Birth

1. DSM V:

   ______ ____
   code ____

   ______ ____
   code ____

   Level of Severity: _______ Mild _______ Moderate _______ Severe

   Date of Diagnosis: _________________________ Date of Last Visit: __________________

   Frequency of office visits: ____

   What is the prognosis and what percent of recovery is expected? ______________________________

2. Is your patient ready to and capable of participating in this rigorous academic environment? Y N

3. Does this condition interfere with one of the following major life activities? (Check all that apply)

_____ walking	_____ hearing	_____ seeing	_____ speaking	_____ caring for one's self
_____ lifting	_____ bending	_____ eating	_____ sleeping	_____ concentrating
_____ working	_____ learning	_____ manual tasks	_____ breathing	
_____ reading	_____ standing	_____ thinking	_____ communicating	

Updated 7/1/19

4. Please describe the functional limitation and/or behavioral manifestations (e.g., easily distracted, poor concentration, difficulty formulating and executing plan of action, difficulty coping with unexpected obstacles, panics in unfamiliar surroundings and situations, etc.) and recommendation you have prescribed:

BEHAVIOR	RECOMMENDATION
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

5. Please list any medications prescribed and the expected side effects, especially on cognition and learning activities.

MEDICATION	SIDE EFFECTS
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

6. Please disclose information you have concerning this student's intellectual capabilities. Please include a copy of any psychological/educational reports for our review.

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Provider's Name: ______________________ Title ______________________ License # ________

Address: ______________________________________ Phone ______________________

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Signature______________________________________ Date ______________________