OFFICE of ACCESSIBILITY SERVICES
PITT COMMUNITY COLLEGE

PO Drawer 7007 • Greenville, NC 27835-7007 • Phone (252) 493-7595 • Fax (252) 321-4345 • Everett-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**: 252-321-4345

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 02/14/22

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 in the box below. Please include a copy of any psychological/educational reports for our review.

Provider's Name: _____ Title _____ License # _____

Address: _____ Phone _____

_____

Signature_____ Date _____