Southeast Arkansas College Office of Disability Services
Psychiatric Disability Documentation Request Form

TODAY’S DATE: ___________________________________________________________
STUDENT’S NAME: _______________________________________________________
HOME ADDRESS: _______________________________________________________
TELEPHONE: ___________________________________________________________

The Southeast Arkansas College student named above is requesting an auxiliary aid or
service, academic adjustment, and/or other accommodations due to a psychiatric disability
from the Office of Disability Services (ODS). In order to consider this request, as well as to
ensure the provision of reasonable and appropriate auxiliary aids and services, College
Policy requires that a qualified professional provide current and comprehensive
documentation of the disability. A qualified professional includes a licensed mental health
professional who is not a family member of the student. In order to be considered current,
the qualified professional’s statement must be **within 6 months** prior to the date of the most
recent request from ODS.

The documentation provided must include information that indicates a diagnosis of a
psychiatric disability (must make a DSM-IV TR diagnosis), describes the functional
limitations in an educational setting, indicates the severity and longevity of the psychiatric
disability for the purpose of determining academic adjustment(s) or other accommodation(s),
and lists current medication and any current side-effects which may impact student
performance. IEP’s and other generalized pieces of information will not be adequate.

Under the Americans with Disabilities Act and the Rehabilitation Act of 1973, an individual
with a disability means any person who:

1. Has a physical or mental impairment which substantially limits one or more major life
   activities;
2. Has a record of such as impairment; or
3. Is regarded as having such impairment, whether he/she has the impairment or not.

“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.

**Please provide the following information:**

Diagnosis (as diagnosed by the DSM-IV):

_________________________________________________________________________

_________________________________________________________________________

Date of Diagnosis: ______________  Date of Last Contact with Student: ______________

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Prognosis:

Describe the student’s functional limitations or restrictions in an educational setting, if any:

Expected date restrictions will be lifted, if any:

Describe clinical evidence of disability, i.e. physical findings, x-rays, lab tests:

Please indicate the recommendations you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student’s educational opportunities at SEARK College as justified based on the functional limitations indicated above.

Qualified Professional's Signature:

Printed Name & Title:

Daytime Telephone Number: _________________________________

Address: _________________________________

Date: _________________________________

Return this information marked confidential to:

Office of Disability Services
Counselor
SEARK College
1900 Hazel Street
Pine Bluff, Arkansas  71603

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Notes: It may be necessary to re-submit documentation for conditions not of a chronic nature. Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.