



**Southeast Arkansas College**  
**Office of Disability Services**  
**1900 Hazel**  
**Pine Bluff, Arkansas 71603**  
**Phone 870-543-5949 Fax 870-373-5107**

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## **Psychiatric Disability Verification Form**

The Office of Disability Services (ODS) 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 ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Southeast Arkansas College (SEARK) generally requires documentation prepared within the last three (3) years. SEARK 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 ODS 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 at ODS, where it will be held strictly confidential.

## STUDENT INFORMATION

First name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth \_\_\_\_\_ Last four digits of SSN \_\_\_\_\_

Status (Check one)  current student  transfer student  prospective student

Cell phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Local 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):

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\* DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The DSM-V was published on May 18, 2013 and is included here. The DSM-V supersedes the SMV-IV which was published in 2000.

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:

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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 (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_