



Office of Student Accessibility and Advocacy
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Verification Form:
Psychiatric Impairments

4.30.20

Albright College's Student Accessibility and Advocacy Office (SAA) has established verification forms to assist in obtaining current information from a qualified professional (Medical Physician, Neurologist/ Neuropsychologists, Clinical Psychologist, Licensed Counselor or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional who has been treating this individual for a minimum of 3 months. In order to assist the student, it is important for us to understand the student's symptoms, related medications, their impact on the student, and their need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores. Any documentation must meet Albright College's documentation standards for the student's condition.

A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Evidence of a disability as defined by the ADAA
- Documentation is no more than 3 years old except in rare circumstances
- Functional impairment affecting an important life skill and how this affects the student in the college environment
- History relevant to the student's disability, including treatments, assistive devices, or other pertinent information
- A clear link between the recommended accommodation and the student's functional limitations
- Summary and recommendations

Student Information: (Please Print Legibly)

Student's Name	
Date of Birth	
Cell Phone Number	
Local Address	
Home Address	

Provider Selection (Please Print Legibly or Type. Illegible documentation will not be processed.)

Date of Initial Contact with Student	
Date of Last Contact with Student	
How long have you been treating the student for THIS condition?	
Frequency of appointments with Student relating to THIS condition (e.g. weekly, once a month, etc.)	

Diagnosis:

What is the student's *primary* diagnosis? _____
 DSM Code _____
 Descriptive Features: _____
 When was the student diagnosed with this condition? _____ (month) _____ (year)
 What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
 Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

Other diagnosis? _____
 DSM Code _____
 Descriptive Features: _____
 When was the student diagnosed with this condition? _____ (month) _____ (year)
 What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
 Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

Other diagnosis? _____
 DSM Code _____
 Descriptive Features: _____
 When was the student diagnosed with this condition? _____ (month) _____ (year)
 What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
 Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

Current Symptoms:

Is there clear evidence that the student's symptoms associated with their diagnosis are interfering with or reducing the quality of at least one of the following within the academic environment? Please explain in the space provided.

Academic Functioning	
Social Functioning	
Work Functioning	

Is there any other historical information related to the student's impairment that you feel is necessary to consider? (medical, psychological, developmental, etc.)

What is the expected duration of the impairment?

Short Term (Less than 6 months)

Episodic

Long Term (6 months – 1 year)

Chronic (More than 1 year with frequent reoccurrences)

Explain why the duration above was chosen.

Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis that you are treating the student for, or any other medication which may impact the student's ability to function in the college environment?

Yes

No

If yes, please provide the information below for each medication the student is prescribed.

Medication/ Dosage/ Frequency	
Date Prescribed	
Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	

Medication/ Dosage/ Frequency	
Date Prescribed	

Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	
Medication/ Dosage/ Frequency	
Date Prescribed	
Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	

Functional Limitations and Recommended Accommodations

It is important for us to understand how the student's current symptoms cause functional impairments in a college environment. Accommodations are not based on the student's diagnosis or medication, but rather on the limitations to his/ her functioning in the educational environment. Based on your knowledge of the student, please provide information regarding what reasonable academic accommodations and the rationale for each accommodation based on the student's symptoms.

Symptom:	
Explanation as to how this symptom effects the student:	
Recommended Reasonable Accommodation(s)	

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Symptom:	
Explanation as to how this symptom effects the student:	
Recommended Reasonable Accommodation(s)	

Provider's Certifying Information	
Symptom:	
Explanation as to how this symptom effects the student:	
Recommended Reasonable Accommodation(s)	

Professionals rendering assessments, diagnosis and providing recommendations for reasonable accommodations must be relevant and qualified to do so (medical doctor, neurologist/ neuropsychologist, psychologist, licensed counselor, etc.). The provider signing

this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Name	
Credentials	
Office or Business Name	
License Number	
State of Licenser	
Street Address	
Office Phone Number	
Email Address or Fax Number	

Directions for Submitting Form and Supporting Documentation:

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation and test results/ scores and other supporting documents directly to the SAA Office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

Albright College- Office of Student Accessibility and Advocacy
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