



## Services for Students with Disabilities

### Psychological Disability Documentation Requirements

To ensure the provision of reasonable and appropriate accommodations on the basis of a disability, students requesting accommodations must provide documentation of their disability as defined by federal law. Title II of the Americans with Disabilities Act (ADA) of 1990 *as amended* and Section 504 of the Rehabilitation Act of 1973 define a disability as a **physical or mental impairment that substantially limits one or more major life activities**. Disability documentation must include:

- a clear diagnostic statement,
- information on the severity of the condition and the resulting impact on a major life activity, and
- details of the typical progression or prognosis of the condition.

In addition, eligibility for academic accommodations is based on the following:

- data in the documentation that clearly demonstrates that a student has one or more functional limitations within an academic setting, and
- these functional limitations require accommodation in order to achieve equal access.

Each accommodation is determined on an individual basis and made available to the extent it meets the students' disability-related needs in an educational setting and does not compromise the academic integrity of the university program.

The attached form may be used to facilitate gathering the necessary documentation. The student should complete and sign the statement below authorizing release of the necessary information and then have his/her medical provider or otherwise appropriately licensed professional complete this form in its entirety. Psychological/psychiatric reports may also be attached if available.

**Please mail or fax the signed Release of Information and completed Verification form to:**

Services for Students with Disabilities  
University of Wisconsin-Eau Claire  
105 Garfield Ave, P.O. Box 4004  
Eau Claire, WI 54702-4004  
Fax: 715-836-3712

### RELEASE OF INFORMATION

I, \_\_\_\_\_, hereby authorize the release of requested information to the **Services for Students with Disabilities Office** at the **University of Wisconsin-Eau Claire** for the purpose of verifying my status as an individual with a disability and determining my eligibility for educational accommodation.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

Please note that this form must be completed by a licensed physician, psychiatrist, clinical psychologist, or otherwise properly credentialed professional who has undergone appropriate and comprehensive training, has relevant experience, and has no personal relationship with the individual to whom this information applies.

## Psychological Disability Verification Form

Please complete all components of this form. Inadequate or incomplete information and/or illegible handwriting will delay the eligibility review process.

**Student Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Diagnosis** (Please provide a clear diagnostic statement or DSM-IV TR codes and description.)

Axis I. \_\_\_\_\_  
Code \_\_\_\_\_

Axis II. \_\_\_\_\_  
Code \_\_\_\_\_

Axis III. \_\_\_\_\_

Axis IV. \_\_\_\_\_

Axis V. \_\_\_\_\_

**Current Level of Severity** (Must check one) Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_

**Date of Diagnosis** \_\_\_\_\_ **Date of Last Appointment** \_\_\_\_\_

**How often do you regularly meet with this patient/student?** \_\_\_\_\_

**Is this diagnosis/condition considered temporary (< 6 month duration)?** \_\_\_\_\_

**Resulting Impact to a Major Life Activity**

Complete the following by comparing patient/student to same age peers in the general population.

**Limitation is:**            0 = None/Unknown            1 = Mild/Moderate            2 = Substantial/Severe

0	1	2	Major Life Activity		0	1	2	Major Life Activity
			Caring for oneself					Speaking
			Performing manual tasks					Breathing
			Seeing					Learning
			Hearing					Reading
			Eating					Concentrating
			Sleeping					Thinking
			Walking/Standing					Other:
			Lifting/Carrying/Bending					Other:
			Working					Other:

**What is the typical progression or prognosis of this condition for this patient/student?**

\_\_\_\_\_

\_\_\_\_\_

**List any medication(s) prescribed and side effects currently impacting this patient/student:**

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**Functional limitations and recommendations for accommodation within an academic environment:**

(\*Disability-related accommodations are intended to ensure equal access and should be based on educational assessment procedures or thorough clinical interviews and observations.)

List how this diagnosis functionally limits this student in an academic environment.	Recommended accommodation in an academic environment.

**What methods did you use to arrive at your diagnosis/recommendations?** *Please check all relevant items.*

- |  |  |
|--|--|
| <input type="checkbox"/> Structured or unstructured clinical interviews with the student           | <input type="checkbox"/> Interviews with other individuals             |
| <input type="checkbox"/> Developmental history   | <input type="checkbox"/> Medical history                               |
| <input type="checkbox"/> Standardized &/or <input type="checkbox"/> Non-standardized Rating Scales | <input type="checkbox"/> Neuropsychological/Psycho-educational Testing |
| <input type="checkbox"/> Other (please specify): _____   |  |

**\*Please attach any assessment data and interpretive reports that would be helpful in determining appropriate accommodations.**

**Licensed Professional information/Credentials** Contact information must be legible.

Name (print):	Clinic/Agency Name if applicable:
Title/Professional Credentials	License #
Street Address:	Phone #
City/State/Zip	Fax #
Licensed Professional's Signature	<i>Thank you</i>