Verification of Psychological Disability

Student Name __________________________________________ Date of Birth __________________________

I am requesting support through the Office of Student/Learner Accommodation Services at UMMS. This requires current and comprehensive documentation of my diagnosis/disability as one of the criteria used to evaluate my potential eligibility for reasonable accommodations/services. I hereby authorize you to complete the following questions and return promptly to the Director of Student/Learner Accommodation Services. I further authorize the Director to contact the provider listed below if clarification is needed.

Student Signature __________________________________________ Date __________________________

Mental Health Provider Name __________________________________________

Title __________________________________________

Organization and Address __________________________________________

Phone __________________________________________ email __________________________________

THE AREA BELOW MUST BE COMPLETED BY THE PROVIDER LISTED ABOVE

1. Date of Diagnosis __________________________ Date last seen __________________________

2. DSM-V Diagnosis: Please list the diagnoses in order of importance, with the principle diagnoses listed first.

________________________________________________________________

________________________________________________________________

________________________________________________________________
3. What were the assessment/evaluation procedures used to make the diagnosis? Please provide historical data that was considered in making the diagnosis.

___________________________________________________________________________________________
___________________________________________________________________________________________

4. Please indicate the major symptoms of the disorder currently manifested including severity:

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<tr>
<th>Symptom</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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5. Please describe course of treatment with you?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

6. Explain the impact of this condition on the student’s ability to learn and or meet the demands of the medical school setting/clinical requirements.

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

7. Recommendations for potential reasonable accommodations:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Signature of Mental Health Provider: ________________________________________________

Date

License type/number: _________________________________________________________________