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Katrina Durham, MS
Director of Student/Learner Accommodation Services

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:

Symptom	Mild	Moderate	Severe

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: _____