CONNECTICUT COLLEGE

Student Accessibility Services
Medical/Psychiatric Disability Verification Form

To Be Completed by Qualified Medical/Psychiatric Provider (may not be a relative of student)

Patient Name: _____

DOB: _____ Patient since:_____

Diagnosis/Date of Diagnosis:
(Using either DSM- 5 or ICD Code) _____

_____ _____

This student has been under a provider's care for this issue since: _____

Date the student was last seen by you: _____

Expectation of the duration of impairment/disability: _____

How often is the patient required to be seen by you: _____
(i.e. weekly, monthly, quarterly, yearly, as needed)

Assessment: **attach relevant test results/reports**
List the Procedures and Evaluations used to make diagnosis:
e.g.: Structured or Unstructured tests, Medical Tests, Behavioral observations, Interviews, Medical and/or Developmental history

Present Condition:
Summarize the present condition and list the date of the most recent evaluation:
Provide the severity of condition: *(mild, moderate, severe)*

Current Treatment Plan:
(include medications, devices, services used to minimize impact of condition)

Major life activities affected in the post-secondary environment:
(Check box in appropriate column for applicable activities)

FUNCTIONAL LIMITATIONS	Mild/Slight	Moderate	Severe
Caring for oneself			
Performing manual tasks			
Seeing			
Hearing			
Breathing			
Sleeping			
Eating			
Standing			
Lifting			
Bending			
Walking			
Speaking			
Learning			
Reading			
Concentrating			
Thinking			
Communicating			
Working			
Operation of a major bodily function			
Other:			

Provide a **detailed** explanation how each relevant major life activity is limited by the student's condition:

Recommended accommodations and justification:
List the specific accommodations recommended, and explain why they are needed. The rationale should focus on the nexus between the impact of the student's diagnosed condition and the recommended accommodations.

State alternatives to meet the documented need if the request cannot be met:

Provider's Signature: _____ Date _____

Provider's Name (print): _____

License/Certification #: _____

Address: _____

City, State, Zip Code: _____

Office Phone #: _____

Return the completed form to sas@conncoll.edu or to the student