CT STATE COMMUNITY COLLEGE

Verification Form for Students with Disabilities

To ensure the provision of reasonable and appropriate accommodations, students must provide documentation which reports the onset, longevity, and severity of symptoms, as well as the specifics describing how it has impacted educational achievement. This form is intended to be completed by a treating medical or mental health provider to assist in meeting our documentation requirements for students with disabilities requesting academic accommodations. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided.

Student Name:	**Student Banner ID#: @**

The information below is to be completed and signed by the treating medical or mental health provider.

1. Please list all DSM-V or ICD-10 diagnoses (name and at least one code):

Diagnosis	DSM-V Code	ICD-10 Code	Date Diagnosed (Month/Year)	Expected Duration (check)
				○ Permanent ○ Chronic/Recurring ○ Temporary ○ N/A
				○ Permanent ○ Chronic/Recurring ○ Temporary ○ N/A
				○ Permanent ○ Chronic/Recurring ○ Temporary ○ N/A
				○ Permanent ○ Chronic/Recurring ○ Temporary ○ N/A
				○ Permanent ○ Chronic/Recurring ○ Temporary ○ N/A

a. Date of initial contact with student:	
b. Date of last contact with student:	

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below:

- ○ Structured or unstructured interviews with student
- ○ Interviews with other persons (i.e., parent, teacher, therapist)
- ○ Behavioral observations
- ○ Neuropsychological testing (Attach documentation)
- ○ Psychoeducational testing (Attach documentation)
- ○ Other (Please specify): _____

b. Current treatment being received by student:
   - ○ Medication management

     Current Medications:
   - ○ Outpatient Therapy

     Frequency:
   - ○ Group Therapy

     Frequency:
   - ○ Other (Please Describe):

3. Functional Limitations

Should be determined without consideration of mitigating measures such as medication. If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

a. Does this condition significantly limit one or more of the following life activities? (Mark with √ or X)

	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown
Communicating					
Concentrating					
Hearing					
Learning					
Manual Tasks					
Reading					
Seeing					
Thinking					
Walking					
Working					
Other:					

b. Please check the functional limitations or behavioral manifestations for this student:

	Not an Issue	Mild Issue	Moderate Issue	Severe Issue	Unknown
Reasoning					
Memory					
Processing Speed					
Meeting Deadlines					
Attending Class					
Organization					
Stress					
Sleep					
Other:					
Other:					

c. Please describe in detail, any functional limitations that fall into the severe range:

d. Special considerations, e.g., medications side effects:

4. **Accommodations**
   a. Has this student utilized accommodations in the past?
      - ○ Yes. Describe:
      - ○ No
      - ○ Not sure

   b. (Optional) Suggested academic accommodations. *Does not guarantee that accommodations would be approved for this particular student or their specific courses.*

Thank you for your help in providing information. Please compete the provider information below. This form should be signed and returned to the student.

Provider Information

I certify that I conducted the diagnostic assessment of the student named above.

Print Name

Credentialed Title **License #**

Phone # **Fax #**

Medical Practice Name & Address

Signature **Date**