Academic Affairs • Office of Student Accessibility Services
118 Beacon Street • Boston, MA 02116
Phone (617) 670-4429 • Fax 617-670-4439

Disability Verification Form – Psychiatric Disability

Student Name:_____Date:_____

Address:_____City:_____State:_____

Phone:_____Email:_____Student ID#:_____

DSM-IV-TR Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (GAF): _____

Date of First Diagnosis:_____*Date of last Clinical Contact*:_____

What is the functional limitation in the academic setting:_____Mild_____Moderate_____Severe

Describe the symptoms (include duration/frequency) of the disorder, how it impacts the student functioning in an academic setting and what might exacerbate these symptoms.

_____
_____

What medications have been prescribed and are there any side effects that may impact the student's academics (Students who are taking medications must inform the College's Nurse)

_____
_____
_____

Recommendations for accommodations given the specific disability (Accessibility Services will consider this to determine services) :

_____
_____
_____

Professional's Name/Title (Print):_____Phone:_____

Address:_____City:_____State:_____

Signature:_____Date:_____

This form must be submitted along with current diagnostic evaluations completed within the past 6 months.