



**EMORY**  
UNIVERSITY

**Accessibility Services**  
**Office of Diversity, Equity,**  
**and Inclusion**

**DISABILITY VERIFICATION FORM  
FOR STUDENTS WITH A MENTAL HEALTH  
DISORDER**

Department of Accessibility Services

1946 Starvine Way, Suite 310

Decatur, GA 30033

Main line: 404-727-9877 Fax: 404-727-1126

*To be completed by diagnosing psychiatrist/psychologist*

The following student \_\_\_\_\_ has asked to register with the Department of Accessibility Services (DAS) at Emory University. DAS requires documentation of the student's disability in order to establish eligibility and provide appropriate services.

Under the Americans with Disabilities Act (ADA) 1990 and Section 504 of the Rehabilitation Act of 1973, students are protected from discrimination and may be entitled to reasonable accommodations. In compliance with the requirements set forth, this form is to verify that a disability exists and accompanying the disability are functional limitations. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and/ or services.

The information you provide will not become a part of the student's academic records but will be kept confidential, and placed into the student's file at DAS. Indicated by the signature below, the student has given permission to release information to Emory University.

**Signature of student** \_\_\_\_\_

**Date** \_\_\_\_\_

After completing this form, please mail or fax the form to the address above. If you have any questions regarding the nature of the information requested on this form, please feel free to contact DAS. Thank you for your assistance.

**1. DSM-IV/V Diagnosis (apply Axis where applicable):**

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Date of initial diagnosis: \_\_\_\_\_

Last contact with student: \_\_\_\_\_

**2. Basis on which diagnosis was made: Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student. If psychological tests were conducted, please include and/or attach copies of testing reports and scores used to support the diagnosis.**

<b>Criteria</b>	<b>Additional Notes</b>
Structured or unstructured interviews with the student	
Interviews with other persons	
Behavioral observations	
Developmental history	
Educational history	
Medical history	
Neuro-psychological testing. Date(s) of testing?	
Psycho-educational testing. Date(s) of testing?	
Standardized or non-standardized rating scales	
Other (Please specify)	

**3. Are there any coexisting conditions, including medical disabilities and learning disabilities that should be considered when providing accommodations?**

**4. Is the student currently on medication? \_\_\_\_\_ Describe medication(s), (date(s) prescribed.**

**How might side effects, if any, affect the student's academic performance?**

**5. Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.**

<b>Life Activity</b>	<b>No Impact</b>	<b>Moderate Impact</b>	<b>Severe Impact</b>	<b>Don't KNOW</b>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely submission of assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making and keeping appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe):				

**6. How long do you anticipate the student's academic achievement will be impacted by this disability?**

<input type="checkbox"/>	Six Months
<input type="checkbox"/>	One Year
<input type="checkbox"/>	More than One Year

**7. Do you have any recommendations regarding effective academic accommodations for the student while attending Emory? (e.g., note-takers, extended time for test)**

**CERTIFYING PROFESSIONAL:**

Printed Name and Title: \_\_\_\_\_

License/Certification #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Number of years working with adult college students: \_\_\_\_\_