Verification of Psychological Disability
Qualified Professional's Statement

Office of Disability Services
P.O. Box 5005
Ashland, VA 23005
Phone: (804) 752-7343
Fax: (804) 752-3744
Email: dss@rmc.edu

Today's Date: _____

Student Name: _____

The above named student is requesting accommodation(s) due to his/her diagnosed disability under the Americans with Disabilities Act. In order to consider this request, as well as to ensure the provision of reasonable and appropriate accommodations, the College requires that current and comprehensive verification be provided by a qualified professional.

To facilitate the gathering of such critical information, please respond to the following questions, attach any appropriate diagnostic reports, and return to Randolph-Macon College, Office of Disability Services.

Please provide the following information:

DSM-V Diagnosis: _____

Date of Diagnosis: _____

Date of your last contact with the student: _____

Prognosis, if applicable: _____

_____

Describe diagnostic evaluation methods, tests and dates of administration. Evaluations must be comprehensive in nature including review of past psychiatric history, family psychiatric history, and medical history. Please state the methods used to evaluate the disability, including but not limited to structured or non-structured clinical interview, projective measures, and/or objective personality instruments. Assessment instruments utilized must be statistically reliable and valid and have age appropriate norms. Please describe or attach appropriate documentation.

_____

_____

_____

_____

_____

_____

Specify the current functional limitations resulting from the disability (*i.e., provide a clear sense of the severity or frequency of how the condition will impact the educational/residential setting*):

_____

_____

_____

Describe restrictions, if any: _____

_____

Expected date restrictions will be lifted, if any: _____

Describe what, if any, accommodations would be reasonable and appropriate. These recommendations should logically relate and support the functional limitations in a classroom or residential setting.

_____

_____

_____

_____

If relevant to the accommodation(s), include information about medications _____

_____

_____

Professional's Signature: _____ **Date:** _____

Printed Name and Title: _____

License #: _____

Address: _____

Daytime Telephone Number: (_____) _____ - _____

Return this verification form and any supplemental information to:

Randolph-Macon College
Higgins Academic Center
Office of Disability Services
P.O. Box 5005
Ashland, VA 23005

Phone: 804-752-7343
Fax: 804-752-3744
Email: dss@rmc.edu