PSYCHOLOGICAL/PSYCHIATRIC

Disability Verification Form

Accessibility Resources Office
P.O. Box 5005
Ashland, VA 23005
Phone: (804) 752-3152

A. STUDENT INFORMATION

_____ _____
Student Name **Student ID**

_____@rmc.edu _____
Student Email **Student Phone Number**

TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

The above-named student is requesting accommodation(s) due to their medical condition under the Americans with Disabilities Act. To consider this request, as well as to ensure the provision of reasonable and appropriate accommodations, Randolph-Macon College (RMC) requests that current and comprehensive verification be provided by a qualified professional. The qualified professional should be a licensed or otherwise properly credentialed individual who has undergone appropriate and comprehensive training and has no personal relationship with the individual being evaluated. The individual making the diagnosis should have credentials directly related to the condition being reported (e.g., an orthopedic limitation should be documented by a physician, not a licensed psychologist). While third-party documentation may be sufficient to establish the presence of a disability, it is not the definitive information that informs the final determination for reasonable accommodations.

HOW TO SUBMIT VERIFICATION FORM:

Fax: (804) 752-3744 - *Attn to: Accessibility Resources Office*
Email: accessibility@rmc.edu
Upload form here: https://bachelor.accessiblelearning.com/RMC/

B. DIAGNOSTIC INFORMATION

1. DSM-V Diagnosis Primary:_____ Secondary:_____

2. Date of Diagnosis: _____/_____/_____

3. In addition to the DSM-V and/or ICD-10 criteria, how did you arrive at your diagnosis? Please check all relevant items below. Please include relevant information in the Notes section.

√	Criteria	Notes (please add information to checked areas)
☐	Structured or Unstructured interviews	
☐	Interviews with other individuals	
☐	Medical tests/history	
☐	Behavioral observations	

☐	Developmental history	
☐	Psychological testing	
☐	Other (please specify)	

C. CONTACT HISTORY

1. How long has the student been under your care for this condition?

   _____

   _____

2. Date of last contact with student: _____/_____/_____

D. IMPACT OF CONDITION

1. How long is the condition expected to persist? ☐ Permanent ☐ Temporary

2. How often is the student required to meet with a provider? _____

3. Are any treatments, medications, or assistive devices/services currently prescribed or used?
   ☐ **YES** ☐ **NO**

4. If **YES**, please list them, along with any side effects or impacts on academic performance. Please include if limitations/symptoms persist even with medication.

Prescribed/Used	**Side Effects/Impacts**	**Academic Impact**	**Do symptoms persist/develop with use**

5. Are there specific symptoms currently present that might affect the student's ability to access RMC's academic opportunities, facilities, or programming? If so, please detail them, including severity and/or frequency of symptoms and any variability in functioning (e.g., episodic, fluctuating, or situational).

   _____

   _____

   _____

6. What is the student's prognosis? How long do you anticipate the student's ability to access RMC's academic opportunities, facilities and/or programming to be impacted by the disability/condition?

_____

_____

_____

7. What major life activities are affected by the student's condition (e.g. concentrating, learning, reading, writing, mobility, caring for oneself, sleep, etc.)?

_____

_____

_____

8. Has there been any changes in the student's condition in the past 12 months?
   ☐ **YES** (please explain below) ☐ **NO**

_____

_____

_____

9. Do you anticipate any changes in the students' condition in the next 12 months?
   ☐ **YES** (please explain below) ☐ **NO**

_____

_____

_____

10. What accommodation(s) do you recommend to support the students' needs?

_____

_____

_____

11. Is there additional information that is related to the student's medical condition and their ability to function academically and/or socially in a college environment?

_____

_____

_____

E. PROVIDER INFORMATION

_____ _____

Printed Name and Title **License #**

_____ _____

Address **City** **State** **Daytime Phone Number**

_____ _____

Provider's Signature **Date**

The Accessibility Resources Office (ARO)will use the information on this form to determine eligibility for accommodations. ARO is committed to ensuring that all information and communication pertaining to a student's disability be kept confidential as required by law.