Office of Disability Services
2121 Euclid Avenue MC 147
Cleveland, Ohio 44115-2214
Phone: (216) 687-2015
FAX: (216) 687-2343
www.csuohio.edu/disability/

Psychiatric Disability Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Cleveland State University generally requires documentation prepared within the last three years. The University reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating of diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified or licensed psychologists, psychiatrists, licensed counselors, hospital records or other mental health professionals.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related information; copies of that report can be submitted for documentation instead of this form.
- After completing this form, sign it, complete the Healthcare Provider information section on the last page and mail or fax it to us at the address provided above. The information that you provide will NOT become part of the student's educational record, but it will be kept with the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

- First name:_____Middle:_____Last:_____
- Date of birth:_____ Last 4 digits of SSN_____
- Status: (Check one)___current student ___transfer student ___prospective student
- Local Phone: (___)_____-_____ Cell Phone: (___) _____-_____

- Address (street, city state and zip code):

_____

_____

Diagnostic Information

1. Date of Diagnosis:_____
2. Date of first contact with student:_____
3. Date of last contact with student:_____
4. DSM-V Diagnosis(es):_____

_____

_____

_____

*DSM IV: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The DSM-V was published on May 18, 2013, and is included here. The DSM-V supersedes the SMV-IV which was published in 2000. DSM-IV diagnosing criteria will still be accepted for individuals bringing forward documentation dated prior to May 18, 2013 and shortly afterwards during this transition period.

5. How did you arrive at your diagnosis?
   ___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-education testing Date(s) of testing? _____
   ___Standardized or non-standardized rating scales _____

6. What is the severity of the condition? Please check one:

   ___Mild ___Moderate ___Severe

Explain severity:

_____

_____

_____

_____

7. Is the student currently receiving therapy or counseling?
   ___Yes ___No ___Not sure

8. What specific symptoms does the student have that might affect his/her academic performance?

_____

_____

_____

9. What is the expected duration of this disability?

_____

_____

_____

10. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Print sign and date below and fill in other fields completely. Please print or type.

Provider's signature:_____Date:_____

Provider's name (Print):_____

Title:_____

License or Certification #:_____

Address:_____

_____

_____

Phone number: (___)_____-_____ FAX number: (___)_____-_____