

Verification Form for Psychiatric Disabilities

Calvin College

Services to students with disabilities, as part of the Office of Academic Services (OAS) strives to ensure that qualified students with psychiatric disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the College programs and services. Federal law defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a mental disorder in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to “substantially limit” one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a psychiatric disability need to have this form filled out by a **psychiatrist, licensed psychologist, certified social worker (CSW or ACSW) or licensed professional counselor**. The professional completing this form must have first hand knowledge of the student’s condition, and must be an impartial professional who is not related to the student.

Release of Information

I, _____, hereby authorize the exchange and release of the following confidential information to Student Academic Services and Calvin College for the purpose of determining my eligibility for educational accommodation.

_____ Date _____ Student’s Signature

Student Information (This section to be completed by the student)

Last Name _____ First _____ MI _____

Student ID# _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Certifying Professional

Name _____

Credentials _____

Address _____

STUDENT NAME: _____

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City _____ State _____ Zip Code _____

Phone _____ Fax _____

License/Certification number and state of licenser _____

Date of initial contact with student _____ Date of last contact _____

Multi-axial DSM IV diagnosis:

Axis I _____

Axis II _____

Axis V _____

Date of Diagnosis _____

Basis on which diagnosis was made _____

If psychological tests were used please include all scores used to support the diagnosis

Current medications including dosage and side effects _____

Long-term medication plan _____

Current compliance with medication plan_ Yes No Other _____

Prognosis for medication plan. (Include likelihood of improvement or further deterioration and within what approximate time frame.)

Planned therapeutic interventions _____

Prognosis for therapeutic interventions. (Include likelihood for improvement or further deterioration and within what approximate time frame.)

Current compliance with therapeutic interventions: Yes No Other _____

Does this person currently pose a threat to him/herself or others? If so please specify in what ways.(continue on back if needed)

STUDENT NAME: _____

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History of hospitalization _____

Implications for Educational Success

Learning abilities specific to the post secondary environment that are impaired by the psychological disability (e.g. difficulty with concentration, slow processing speed, etc.)

Implications for taking exams and other classroom activities caused by the disability or treatment. Please specify which.

Suggested accommodations (Final determination of appropriate accommodations will be determined by our office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.) Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed.

Extension of time to complete exams

Why? _____

Quiet room in which to take exams

Why? _____

Extension of a deadline to complete an assignment

Why? _____

Other (please specify)

Why? _____

This form should be returned to:

Calvin College
Office of Academic Services
Attn: Services to Students with Disabilities
1845 Knollcrest Circle SE
Grand Rapids, MI 49546
Phone #: (616) 526-6113
Fax #: (616) 526-7066

STUDENT NAME: _____