THE UNIVERSITY OF TENNESSEE KNOXVILLE

PSYCHOLOGICAL VERIFICATION FORM

Students requesting accommodations may be required to submit documentation to verify eligibility under the ADA of 1990 and Section 504 of the Federal Rehabilitation Act of 1973. Appropriate documentation of the disability allows the Office of Disability Services (ODS) to determine the student's eligibility for accommodation and the appropriate academic accommodations. **PLEASE NOTE** that students should not delay meeting with ODS out of concern for not having the correct (or any) documentation. If needed, the Coordinator can discuss with the student any specific documentation needs during the Welcome Meeting. **Our priority is on meeting with students and beginning the accommodations process for them as soon as possible.** Provisional accommodations may be provided to allow students time to procure any needed documentation.

The following form is provided in the interest of assuring that the documentation validates the presence of a psychological disability, demonstrates an impact of the disability on learning, and supports the request for accommodations and services.

1. 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 psychiatrist, psychologist or social worker.

2. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. It is recommended that this form be completed by typing the information into the editable PDF version of the form available on our website at: http://ods.utk.edu/files/psychverificationform.pdf

3. The healthcare provider should attach additional reports if available which provide related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. *Please do not provide case notes or rating scales without a narrative that explains the results.*

4. **After completing this form, please sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to us at the address provided in our letterhead.** The information you provide will not become part of the student's educational records, but it will be kept in the student's file at ODS, where it will be held strictly confidential. This form may be released to the student at his/her request. If you have questions regarding this from, please call the ODS office at 865-974-6087. Thank you for your assistance.

STUDENT INFORMATION - to be completed by student
(Please Print Legibly or Type)

Name: _____
First Middle Last

Date of Birth: _____UT ID#: _____

Status (check one): ☐ current student ☐ transfer student ☐ prospective student

Phone: _____Circle one: ◉ Campus ○ Local ○ Parent's ○ Cell

Phone: _____Circle one: ◉ Campus ○ Local ○ Parent's ○ Cell

Current/Campus Address (If unknown, leave blank):

_____

_____

Permanent/Home Address:

_____

_____

If a University of Tennessee student, UT email address: _____@utk.edu

Alternative email address: _____

DIAGNOSTIC INFORMATION - to be completed by healthcare professional
(Please Print Legibly or Type)

1. Date of Diagnosis: _____
2. Date student was last seen: _____
3. DSM-5 diagnosis:

   Axis I: _____

   Axis II: _____

   Axis III: _____

Axis IV: _____

Axis V (GAF Score): _____

4. In addition to DSM-5 criteria, 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
   ☐ Neuropsychological testing, if so, dates of testing: _____
   ☐ Psycho-educational testing, if so, dates of testing: _____
   ☐ Standardized or non-standardized rating scales
   ☐ Other (please specify):_____

5. What is the severity of the disorder? ☐ mild ☐ moderate ☐ severe

   Please explain the severity checked above:

   _____

   _____

   _____

   _____

6. What is the expected duration of this disability?

   _____

   _____

   _____

   _____

   _____

7. Major Life Activities Assessment:

   Please check which of the following major life activities listed above are affected because of the impairment. Indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Don't Know
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Regular Attendance	☐	☐	☐	☐
Keeping Appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing Internal Distractions	☐	☐	☐	☐
Managing External Distractions	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

8. Please describe the student's symptoms relation to this diagnosis.

   _____

   _____

   _____

   _____

9. What specific symptoms does the student have that might affect the student's academic performance?

   _____

   _____

   _____

   _____

   _____

10. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

_____

_____

_____

_____

_____

_____

11. What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

_____

_____

_____

_____

_____

12. Is this student currently receiving therapy or counseling?

☐ Yes ☐ No ☐ Not Sure

13. 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.

_____

_____

_____

_____

_____

_____

_____

14. If the current treatments (i.e. medications and therapy) are successful, state the reason the above academic adjustments, auxiliary aids, or services are necessary.

_____

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and fill in all other fields completely using PRINT or TYPE)

Provider Signature: _____ **Date:** _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

_____

Phone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

By signing this form, the heath care professional certifies that they are an appropriately certified or licensed professional and have been trained in psychiatric, psychological, or neuropsychological assessment.