Indiana University Southeast Office of Disability Services
Psychiatric Disability Verification Form
(To be completed before each semester in which a student wishes to use accommodations)

Student Information
Name: __________________________________________________________________
Indiana University Southeast student ID: ____________________

Provider Information
(Please sign and complete fully)
Provider Name (print): __________________________________________________
Title: ________________________________________________________________
License or Certification #: _______________________________________________
Address: _____________________________________________________________
Phone: (_____) _____________________ Fax: (____) ________________________

DIAGNOSTIC INFORMATION
Please provide responses to the following items by typing or writing clearly. Illegible forms will delay the documentation review process for the student.

1. Date of Diagnosis: ______________________________________________
2. Date student was last seen: _______________________________________
3. DSM-IV Diagnosis
   a. Axis I: ______________________________________________________
   b. Axis II: _____________________________________________________
   c. Axis III: ____________________________________________________
   d. Axis IV: ____________________________________________________
   e. Axis V (GAF Score): __________________________________________

4. What is the severity of the condition? Please check one:
   □ mild            □ moderate            □ severe

6. What is the expected duration of this disability?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

7. Major Life Activities
Please check which of the following major life activities listed above are affected because of the impairment and indicate severity of limitations.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<tr>
<td>Memory</td>
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<td>Eating</td>
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<td>Social Interactions</td>
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<td>Self Care</td>
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<td>Regular Attendance</td>
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<td>Keeping Appointments</td>
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</table>
8. 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. Is the student currently receiving therapy or counseling?
_____________________________________________________________________

12. What medications is the student currently taking? If so, how might side effects, if any, affect the student’s academic performance?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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

Provider Signature: ________________________________ Date: _____________

All documentation is confidential