



## Psychological Disability Verification Disability Resource Center

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One Washington Square – San José, CA 95192-0168 - Voice: 408-924-6000; TTY: 408-924-5990; Fax: 408-924-5999

To Evaluator:

To qualify for support services from the San José State University Disability Resource Center, a student must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive. In most cases, documentation should be based on a comprehensive diagnostic/clinical evaluation. The report must include a specific diagnosis based on the DSM-IV. Evaluators are encouraged to cite the specific objective measures used to help substantiate the diagnosis. The evaluator should use direct language in the diagnosis of a psychiatric disorder, avoiding the use of such nonspecific terms as “suggests”, “has problems with”, or “may have emotional problems.”

Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DSM IV: \_\_\_\_\_

- *Axis I*
- *Axis II*
- *Axis III*
- *Axis IV*
- *Axis V*

Date of Diagnosis: \_\_\_\_\_

Duration: (check one):  Long-term  Permanent

If not permanent, how long will the impairment likely last?

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(specify dates)

Does the impairment affect a major life activity?      Yes       No

If yes, what major life activity(ies) is/are affected?

- |  |                                   |                                       |  |
|--|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Caring for Self         | <input type="checkbox"/> Walking  | <input type="checkbox"/> Hearing      | <input type="checkbox"/> Lifting       |
| <input type="checkbox"/> Interacting w/others    | <input type="checkbox"/> Seeing   | <input type="checkbox"/> Sleeping     | <input type="checkbox"/> Standing      |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking     | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Breathing               | <input type="checkbox"/> Thinking | <input type="checkbox"/> Learning     | <input type="checkbox"/> Working       |
| <input type="checkbox"/> Toileting               | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Reproduction |  |
| <input type="checkbox"/> Other (describe): _____ |                                   |                                       |  |

Is the patient/client limited in one of more of these major life activities?    Yes     No

**Description of current functional limitations in the academic environment as well as across other settings:**

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**Specific information regarding any prescribed medications:**

Medication(s) prescribed: \_\_\_\_\_

Quantity or dosage: \_\_\_\_\_

Anticipated side effects which may impact the students in an academic setting environment.

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**Relevant information regarding current treatment**

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Psychoeducational, neuropsychological or behavioral assessments are often necessary to support the need for accommodations based on the potential for psychiatric disorders to interfere with cognitive performance.

List assessments used:

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If patient is following a treatment plan, please send a copy. For general questions pertaining information requested, please contact the Disability Resource Center at 408-924-6000.

**Certifying Licensed Psychiatrist, Clinical Psychologist or Licensed Therapist.**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Last, First M.I. (Please Print)

Medical Facility \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

License #: \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_