SAMUEL MERRITT UNIVERSITY

PSYCHOLOGICAL DISABILITY VERIFICATION

The student named below may be eligible for accommodations at Samuel Merritt University. In order to determine appropriate accommodations, Samuel Merritt University must have verification of a disability and of the resulting functional limitations. Information on this form will be used in confidence for the educational benefit of the student. This information will be kept strictly confidential.

First Name Middle Initial Last Name Date of Birth

DSM-V or DSM-IV-TR Multi-Axial Diagnosis (es)

Axis I:

Diagnosis Date of Dx

Axis II:

Diagnosis Date of Dx

Axis III: Other Medical Conditions: _____

Axis IV: Psycho-social & Environmental Stressors: _____

Axis V: _____/_____

Current Global Assessment of Functioning Highest Global Assessment of Functioning

Describe the functional limitations and the severity of impact on the student in an educational setting:
(Please note that accommodations will be determined based on documented, specific functional limitations).

Describe medications prescribed and any side effects/functional limitations resulting from treatments or medications:

Describe possible accommodations that could ease the impact of the disability treatment or medications on academic tasks:

The above documented diagnosis is: _____ permanent/chronic _____ temporary until _____
Month/Date/Year

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Certifying Professional

Diagnoses must be within the professional expertise and scope of practice of the certifying professional.

Name (typed or printed) Signature

Title License No. Today's Date

Address City State Zip Telephone FAX

PLEASE RETURN THIS FORM TO THE STUDENT OR FAX THIS COMPLETED FORM TO: (510) 869-1551