Samuel Merritt University

Certification of Psychological Disability

Disability Resource Center
Samuel Merritt University
3100 Telegraph Ave. Suite 1000
Oakland, CA 94609
Phone: 510-879-9233
Fax: 510-457-2628

The student named below has applied for services from the Disability Resource Center (DRC) at Samuel Merritt University. In order to determine eligibility and to provide services, we require documentation of the student's psychological disability.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

The information you provide will not become part of the student's educational records, but will be kept in the student's file at DRC, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

Student's Name: _____

Today's Date: _____/_____/_____
Month Day Year

DSM-5: Please include all relevant diagnostic information including subtypes and/or specifiers for diagnostic domains and subgroups (as indicated in DSM-5) including V/Z codes: psychosocial and environmental stressors.

Focus of Clinical Treatment:	(Please provide all pertinent DSM-05 codes or diagnoses.)
Psychosocial or environmental stressors:	
Medical Conditions:	

Which specific symptoms might affect the student's academic performance?

Date of above diagnosis: _____/_____/_____
Month Day Year

Date student was last seen: _____/_____/_____
Month Day Year

How long has the student been under your care?

How long do you anticipate the student's academic functioning will be impacted by this disability?

◯ Six months ◯ One year ◯ More than one year

Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Concentrating				
Memory				
Sleeping				
Eating				
Social interactions				
Self-care				
Managing internal distractions				
Managing external distractions				
Timely submission of assignments				
Attending class regularly and on time				
Making and keeping appointments				
Stress management				
Organization				

Is this student currently taking medications(s) for these symptoms? ◯ Yes ◯ No

If any of these medications have or may have an effect on academic functioning, please list the medication and the actual or possible effects.

Certifying Professional*

_____ _____

Signature of Professional Date

_____ _____

Professional's Name (printed) and Title License No.

_____ _____

Address Telephone Number

_____ _____

City, State, ZIP Code -Fax Number

* Qualified diagnosing professionals would include, but are not limited to, licensed psychologists, psychiatrists, and neurologists, or other professionals with training and expertise in the diagnosis of mental disorders.

I request that the information below be provided to DRC in order to determine my eligibility for the program and to obtain program services

_____ _____

Signature of Student Date

I authorize DRC and Samuel Merritt University to coordinate relevant information when necessary to support the efficient provision of DRC services and health care services on my behalf. This authorization will remain valid for the duration of my time as a student at Samuel Merritt University. I understand I may revoke this authorization at any time by submitting a written request to revoke to Disability Resource Center.

_____ _____

Signature of Student Date