Verification of Psychological Disability

Accessibility Resources at the University of Cincinnati provides accommodations to students with medical disabilities. To determine eligibility for services, this office requires current and comprehensive documentation of the condition from a licensed mental health professional.

Please answer the following questions pertaining to:

Student: ________________________________________________

**Primary Diagnosis:** (Include DSM-5 axes as appropriate)

__________________________________________________________________________________
__________________________________________________________________________________

Date of Diagnosis: ___________________ Date of last contact with student: ______________

Describe symptoms /behavioral manifestations associated with diagnosed condition:

__________________________________________________________________________________
__________________________________________________________________________________

List prescribed medication(s), dosage, frequency, and adverse side effects (if applicable):

__________________________________________________________________________________
__________________________________________________________________________________

Does this condition or medication prescribed for this condition cause substantial limitations in the academic environment? If yes, please describe.

__________________________________________________________________________________
__________________________________________________________________________________

The following academic accommodations may or may not be appropriate for this student. Please indicate those, which you believe, will reduce the impact of symptoms, medication side effects, and/or behavioral issues in the academic environment.

Peer Note taker ______
Use of an in-class Tape Recorder ______
Distraction-free Testing Environment ______
Extended Time for Testing: ______ +50% ______+100%

Other: ________________________________________________
Licensed Professional’s Signature: ______________________________________________________

Print Name & Title: __________________________________________________________________

Address: ___________________________________________________________________________

_________________________________________________________________________________

Phone: _____________________________________________________________________________

Date: ______________________________________________________________________________

Please send this form and any supporting documents (psycho-educational testing) to:

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