



# CHAPMAN UNIVERSITY

## CERTIFICATION OF PSYCHOLOGICAL DISABILITY

The student named below has applied for housing accommodations from the Office Residence Life and First Year Experience. In order to determine eligibility and to provide services, we require documentation of the student's psychological disability. Under the Americans with Disabilities Act as Amended (ADAAA) of 2008 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 be reliable and support the requested accommodation(s). Determination of accommodations will be done by Office of Residence Life and First Year Experience.

Please upload completed form to Accommodate Portal. The information you provide will *not* become part of the student's academic records, but will be kept in the student's file at Residence Life and First Year Experience, where it will be held in accordance with federal laws regarding privacy of student records. 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 (please sign this form before providing it to your mental health care provider to complete):**

By signing below, I consent to allowing my health care provider to share any information relevant to my need for disability related accommodations, as shown on this form, with (personnel from the Office of Residence Life and First Year Experience) for the next 60 days.

Student Name (Print) \_\_\_\_\_ (signature) \_\_\_\_\_ Date \_\_\_\_\_  
Student email: \_\_\_\_\_

### **TO BE COMPLETED BY THE LICENSED PROVIDER (incomplete information may nullify this request):**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Initial Date of Diagnosis (below): \_\_\_\_\_ Date of most recent appt: \_\_\_\_\_  
Dates of sessions in the last 6 months for this diagnosis (required): \_\_\_\_\_

**What is the nature of the student's mental health impairment? Please specify.  
DSM-V DIAGNOSIS (include DSM V or ICD 10 Codes, include subtypes and specifics)**

Principle Diagnosis: \_\_\_\_\_  
Other Diagnosis: \_\_\_\_\_  
Other Diagnosis: \_\_\_\_\_

1. In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, **adding brief notes that you think might be helpful to us as we determine which access accommodations and services are appropriate for the student.**

#### **Check Assessment or Evaluation Procedure use to Make Diagnosis**

<input type="checkbox"/> Structured or unstructured interviews with the student	<input type="checkbox"/> Interviews with other persons
<input type="checkbox"/> Developmental history	<input type="checkbox"/> Behavioral observations
<input type="checkbox"/> Neuropsychological testing: Date(s) of testing- Attach Report	<input type="checkbox"/> Medical history
<input type="checkbox"/> Psychoeducational testing: Date(s) of testing- Attach Report	<input type="checkbox"/> Educational history
<input type="checkbox"/> Standardized or non-standardized: Rating scales – <b>Attach Report(s)</b>	

**Notes (to assist in determining accommodations):**

2. What medications have you prescribed the student? ☐ N/A, I do not prescribe medication.

List Side effects: ☐ No Known Side Effects; or ☐ \_\_\_\_\_  
Effectiveness of Medication(s): ☐ Very Effective ☐ Moderately Effective ☐ Somewhat Effective ☐ Unknown

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

Life Activity	Rate the Impact					Notes
	N/A	Mild	Moderate	Severe	Don't Know	
Concentration/Focus						
Managing internal stimuli (thoughts)						
Managing external stimuli						
Information Processing						
Organization / planning						
Initiation- difficulty getting started						
Recall/Memory						
Motivation (identifying reasons to act)						
Difficult Making Decisions						
Issues with energy						
Stress management						
Emotional regulation						
Social interactions						
Distress Tolerance						
Eating						
<input type="checkbox"/> Insomnia / <input type="checkbox"/> Hypersomnia						

4. What other specific symptoms are manifesting themselves at this time that might affect the student's academic performance?

5. If there are flare up, please provide frequency, intensity, and duration (i.e., hospitalizations). Also, what other symptoms, if any are present during a flare up?

6. Prognosis: How long do you anticipate the student will be disabled?

Check One: ☐ 3 months or less ☐ ≈ 6 months ☐ ≈ 1 year ☐ Permanent/Chronic ☐ Unknown  
**Why?**

7. Treatment Plan: How often will you be seeing the student for treatment of this diagnosis?

☐ No f/u appointments scheduled ☐ Specify frequency: \_\_\_\_\_ ☐ Telehealth ☐ In-Person

8. Is there anything else you think we should know about the student's disability?

CERTIFYING LICENSED PROFESSIONAL \* must be eligible to practice without supervision.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

License Number: \_\_\_\_\_ Date: \_\_\_\_\_

☐ Psychologist ☐ Psychiatrist ☐ Neurologist ☐ Primary Care Physician ☐ LCSW/LMFT

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Website: \_\_\_\_\_ email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

\* The diagnosing professional must be **licensed to work independently** and have expertise in the differential diagnosis of the documented mental disorder and follow established practices in the field. *Practitioners who function under physician oversight (e.g., PA, NP...), or licensed mental health care professionals (e.g. Psych intern, MFTI,...), must have this form signed by the supervising license.*

**\*In accordance with professional ethics, this form may not be completed by a family member.**

Certification of Psychological Disability