The student named below has applied for services from Disabilities Support Services (DSS) at Chattanooga State. The college provides academic services and accommodations to students with psychiatric/psychological disabilities. Students seeking services must provide appropriate medical documentation of their condition so that DSS can: 1) determine the student’s eligibility for accommodations, and 2) if the student is eligible, determine appropriate academic accommodations.

The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.” Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Documentation required to verify the student’s condition and its severity, includes completion and return of this form to DSS by a professional with the appropriate training and credentials. Depending on the student’s condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and licensed mental health professional. Information on any medications prescribed for the condition must be documented by the professional prescribing the medication. Any professional completing this form must have first-hand knowledge of the student’s condition, experience in working with college students with psychiatric/psychological conditions and a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnosis of psychiatric/psychological disabilities documented by family members is unacceptable. Due to the nature of this type of disability, documentation must be within the last year. Students who return to Chattanooga State after a year or more absence must provide updated documentation.

**Student:** Complete this section

Last Name _____________ First Name _____________ Middle Initial _____________

Date of birth: ______________________________
Certifying Professional (Psychiatrist /Psychologist, or other approved diagnostician) Complete the following sections

Printed Name: _______________________________________________________

Signature: _______________________________________________________
Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.

License Type: _______________________________________________________

License Number: _______________     State:  _____     Exp Date:  _________
Mailing Address: _________________________________________________

City/State/Zip:  _________________________________________________

Phone:  (_____)_________________________________
Fax:  (_____)_________________________________
Email:  _______________________________    Today’s Date:_____________

Diagnostic and Statistical Manual Diagnosis (DSM)

Axis I:  _____________________  Code: _____________________

Axis II: _____________________  Code: _____________________

Axis III: _____________________  Code: _____________________

Axis IV: _____________________  Code: _____________________

Axis V:  _____________________  GAF Score: _______________

Primary diagnosis/diagnoses and date of onset: _______________________________

Student’s last appointment: (check one)

less than 1 month    less than 1 year    greater than 1 year
Appointment frequency: (check one)

weekly  monthly  annually  as needed

Expected duration of primary condition: (check one)

permanent  temporary

How long do you anticipate that the student’s academic achievement will be impacted by the primary condition? (Check one)

less than 6 months  less than 1 year  greater than 1 year

Student’s prognosis?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
__________________________________________________

Diagnostic Tools

In addition to DSM criteria, how did you arrive at your diagnosis/diagnoses? Please check any relevant items below.

☐ Interviews with the student

☐ Interviews with other person

☐ Behavioral observations

☐ Developmental history

☐ Neuro-psychological testing

☐ Psycho-educational testing

☐ Self rated or interviewer rated scales

☐ Other
Medication and Prescribed Aids

1. What medication, counseling therapy, and/or prescribed aids are currently being used in the treatment of the diagnosis/diagnoses above?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

2. Describe any medication side effects that may adversely affect the student’s academic performance.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

3. Describe any other relevant aspects of this condition that may impact educational or interpersonal behavior and achievement.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

4. From your medical perspective, describe possible accommodations that could facilitate the student’s academic performance.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Please indicate the current functional limitations of the student regarding the major life activities listed below. Circle the degree of limitation and provide any necessary comments.

<table>
<thead>
<tr>
<th>Functional Limitation</th>
<th>Degree of Limitation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentration</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Information Processing</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Managing Internal Distractions</td>
<td>Mild</td>
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<tr>
<td>Managing External Distractions</td>
<td>Mild</td>
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<td>Organization</td>
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<td>Stress Management</td>
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<tr>
<td>Social Interaction</td>
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</tr>
<tr>
<td>Activities of Daily Living</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Mild</td>
<td></td>
</tr>
</tbody>
</table>