CAPE COD COMMUNITY COLLEGE
O'NEILL CENTER FOR STUDENT ACCESS AND SUPPORT

2240 Iyannough Rd. West Barnstable, MA 02668-1599
(508) 375-4110 (fax)

VERIFICATION OF PSYCHIATRIC / MENTAL HEALTH DISABILITY

DATE: _____

TO: _____

FROM: __ Douglas Terry
Coordinator, Disability Services
dterry@capecod.edu
(508) 362-2131 Ext. 4337

__ Richard H. Sommers, Ph.D.
Learning Disabilities Specialist
Lic. Clinical Psychologist
rsommers@capecod.edu
(508) 362-2121 Ext. 4317

_____ is a student at Cape Cod Community College who is requesting academic accommodations/services through our Office. In order to determine this student's eligibility for academic adjustments/modifications under the Americans with Disabilities Act, and to ensure the provision of such services, the College requires documentation of the disability. Your assistance in furnishing pertinent psychological information that would enable us to accurately assess this student's special needs would be greatly appreciated. ***NOTE: See reverse side of this form for questionnaire to be completed by an appropriate licensed practitioner.***

Academic accommodations for students with psychiatric/mental disabilities may include extended time on exams, tutors, word processing and adaptive computer technology. Each student is assessed on his/her special needs with appropriate documentation.

Student authorization to release information

I hereby authorized the above named psychologist/psychiatrist/neurologist to release information regarding my disability to the O'Neill Center at Cape Cod Community College. I understand that the information will be used for documentation of my disability and to ensure the provision of reasonable and appropriate services. Furthermore, I understand all information provided will be held in strict confidence as specified in the rules and regulations of Cape Cod Community College.

Student Signature: _____ Date: _____

Patient's name:_____

Psychiatric Information to Document Mental Disorder

To Be Completed By Psychiatrist/ Clinical Psychologist/ Neurologist/ Psychiatric Nurse Practitioner

(A comprehensive Psychiatric report may be attached in lieu of completing this form)

1. **DSM-V/DSM-IV Classification:**_____

2. DSM-V/DSM-IV Criteria (symptoms) related to diagnostic category.
   (Describe the symptoms, severity and longevity of the condition related to and that substantiate the diagnostic category.)

3. Date of onset, last date patient seen, type of evaluation conducted and treatment plan. If no treatment is being provided, please explain why the condition is severe enough to be considered a disability.

4. List medications and any side effects that maybe important in developing an education plan.

5. Describe the substantial limitations to major life activities posed by the psychiatric disability and describe the extent to which these limitations would impact the academic context.

6. You may offer suggestions for appropriate and reasonable accommodations at the post- secondary educational level.

Signature: _____ Date: _____

Print Name and License Title: _____

Address: _____

_____ Phone: _____

Email: _____