Verification Form for Mental Health Condition

Grand Valley State University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the University’s programs and services. Federal law defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to “substantially limit” one or more major life activities.

The office of Disability Support Resources (DSR) strives to insure that qualified students with mental health conditions are accommodated, and if possible, that the accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life functions.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a mental health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the student’s condition, must have experience diagnosing and treating college students, and will be an impartial professional who is not related to the student.

Student Information

Last Name ________________________________ First __________________ Middle Initial _____

Date of Birth __________ Address _____________________________________________________

City __________________________ State __________________________ Zip Code __________

Certifying Professional

Name _____________________________________________________________

Credentials _________________________________________________________________________

Address ___________________________________________________________________________

City __________________________ State __________________________ Zip Code __________
License/Certification number and State of Licensure __________________________________________

Years of experience working with college students ____________________________________________

Date of initial contact with student ________________________________________________________

Date of last contact with student __________________________________________________________

**Multi-axial DSM IV Diagnosis:**

Axis I __________________________________________________________________________________

Axis II __________________________________________________________________________________

Axis IV __________________________________________________________________________________

Date of Diagnosis _________________________________________________________________________

Basis on which diagnosis was made ___________________________________________________________________________________________________________

If psychological tests were used please include all scores used to support the diagnosis

_____________________________________________________________________________________

_____________________________________________________________________________________

If the diagnosis includes a phobic response to exams, does the problem pose a substantial limitation to the student demonstrating their knowledge of the class material on an un-accommodated exam?

Yes ___  No ____

Explanation ___________________________________________________________________________

_____________________________________________________________________________________

Current medications including dosage and side effects _________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Long term medication plan _______________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
Current compliance with medication plan

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________

Prognosis for medication plan (Include likelihood of improvement or further deterioration and within what approximate time frame)

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________

Planned therapeutic interventions

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________

Prognosis for therapeutic interventions (Include likelihood of improvement or further deterioration and within what approximate time frame)

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________

Current compliance with therapeutic interventions

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________

History of hospitalization

________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________
Implications for Educational Success

Learning abilities specific to the post-secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

Implications for taking exams and other classroom activities caused by the disorder or medication. Please specify which

Suggested accommodations (Each recommended accommodation should include a detailed explanation of its relevance to the disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the individual is currently functioning even with the benefits of treatment):

- Extension of time to complete exams:
  Why?

- A quieter room in which to take exams:
  Why?

- Others: (please specify)
  Why?

Final determination of appropriate accommodations will be determined by the DSR Office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, court rulings, and the Department of Education Office of Civil rights rulings related to these two laws.

If you have any questions regarding the nature of the information needed for students with mental health conditions, please call Disability Support Resources at (616) 331-2490, Monday through Friday from 8:00 am to 5:00 pm Eastern Standard Time. This form should be returned to 4015 James H. Zumberge Hall, Grand Valley State University, Allendale, Michigan, 49401.
This document may not be released without written permission from the student or by order of a court. It will be destroyed after three years after the student is no longer enrolled. The student will have access to this document but you may specify that this access by given when there is a person qualified to explain the document is available.

________________________________________________________

SIGNATURE OF CERTIFYING OFFICIAL                 DATE