4015 James H. Zumberge Hall
1 Campus Drive
Allendale, MI 49401
www.gvsu.edu/dsr

GRAND VALLEY STATE UNIVERSITY
DISABILITY SUPPORT RESOURCES

OFC: (616) 331-2490
TDD: (616) 331-3270
Fax: (616) 331-3880
E: dsrgvsu@gvsu.edu

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 mental 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 individuals with mental health conditions are accommodated, and if possible, that their 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 function.

This form is designed to allow us to achieve these goals. Individuals wishing to receive 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 persons of college age and will be an impartial professional who is not related to the student. **NOTE: Form may not be used as documentation for Assistance Animals or Housing Accommodations.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

Student Information

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Address _____

Phone_____ City _____ State _____ Zip Code _____

Certifying Professional (This section must be completed by the certifying professional)

Name _____

Credentials _____

Address _____

Phone_____ Fax_____ City _____ State _____

Zip Code _____ License/Certification number and State of Licensure _____

REQUIRED

Attach Business Card Here

Or
If Submitting Electronically, Denote Your Office Web Address

Years of experience working with this patient_____

Date of initial contact with this patient_____

Date of last contact with this patient_____

DSM 5 Diagnoses:

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 intervention and its nexus to the disability (i.e., cognitive-behavioral therapy, medication, psycho-educational):

_____

_____

_____

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: _____

_____

Describe the functioning limitations resulting from the disability or disabilities: _____

_____

_____

<u>Implications for Educational Success</u> (For Students Seeking Academic Accommodations only)

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 _____

_____

_____

☐ Please specify the necessary accommodations for academic success. Why?

_____

_____

_____

If you have any questions regarding the nature of the information needed for 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 Grand Valley State University, 4015 James H. Zumberge Hall (4015 JHZ), 1 Campus Drive, Allendale, Michigan, 49401.

_____ _____

Signature of Certifying Official Date