Cleveland State
COMMUNITY COLLEGE
ACCESS Center
Student Center • RM 118
3535 Adkisson Drive • Cleveland, TN 37320
Phone: (423) 478-6217

Psychiatric/Psychological Disability Certification

The student named below has applied for services from Disability Support Services (DSS) at Cleveland State Community College. 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.

Documentation required verifying 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 is a licensed psychiatrist, psychologist, neuropsychologist, or other qualified and licensed mental health professional.** A Medical Doctor (MD) that is not a licensed mental health professional does not qualify. 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 a family member is unacceptable. Due to the nature of this type of disability, documentation must be within the last year. Students who return to Cleveland State after a year or more absence must provide current documentation. For additional information regarding documentation guidelines, refer to the **Educational Testing Services** *(ETS)* guidelines at *www.ets.org*.

Student's Name: ______________________________ Student ID: N______________

Last Four Digits of SSN: ____________

Certifying Professional: Complete this and all subsequent sections

Name of Patient: ______________________________ Date: ____________

Diagnostic and Statistical Manual Diagnosis ***(DSM–IV-TR)***

Axis I: ______________________ Code*(s)*: ______________

Axis II: ______________________ Code*(s)*: ______________

Axis III: ______________________ Code: ______________

Axis IV: ______________________________

Axis V: GAF = ________

Student Name: ______________________ **ID Number:** ______________

Diagnostic and Statistical Manual Diagnosis ***(DSM-5)***

Primary Diagnosis	Code
V- Codes or Z-Codes	**WHODAS** *(if used)*

Date of onset of primary diagnosis ______________________

Student's last appointment:
- ❑ Less than 1 month
- ❑ Less than 1 year
- ❑ Greater than 1 year

Appointment frequency:
- ❑ Weekly
- ❑ Monthly
- ❑ Annually
- ❑ As Needed

Expected duration of primary condition:
- ❑ Permanent
- ❑ Temporary

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

- ❑ Greater than 6 months
- ❑ Greater than 1 year
- ❑ Less 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
- ❑ Self-rated or interviewer rated scales
- ❑ Other: ______________________

Medication and Prescribed Aids

1. What medication and 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.

Student Name: ______________________________ **ID Number:** ______________________

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

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

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Functional Limitations

Please indicate the functional limitation(s) of the student regarding the major life activities listed below. Circle the degree of limitation and provide any necessary comments.

Functional Limitation	Degree of Limitation	Comments
Concentration	❑ Mild ❑ Moderate ❑ Severe	
Memory	❑ Mild ❑ Moderate ❑ Severe	
Information Processing	❑ Mild ❑ Moderate ❑ Severe	
Managing Internal Distractions	❑ Mild ❑ Moderate ❑ Severe	
Managing External Distractions	❑ Mild ❑ Moderate ❑ Severe	
Organization	❑ Mild ❑ Moderate ❑ Severe	
Stress Management	❑ Mild ❑ Moderate ❑ Severe	
Social Interaction	❑ Mild ❑ Moderate ❑ Severe	
Activities of Daily Living	❑ Mild ❑ Moderate ❑ Severe	
Other: ______________	❑ Mild ❑ Moderate ❑ Severe	

Name of Professional: ______________________________ License Type: ____________

License Number: ______________________ State: ________ Expiration Date: ____________

Mailing Address: ____

City: ______________________________ State: ________ Zip: ____________

Phone: ________________ Fax: ________________ Email Address ______________________

Signature: ____

signature denotes content accuracy, adherence to professional standards and guidelines Date: ____________

Please return completed form to:

Counselor/Coordinator of Disability Support Services
Cleveland State Community College
3535 Adkisson Drive, P.O. Box 3570, Cleveland, TN 37320-3570
Fax: (423) 614-8724 Phone: (423) 473-2427