DES MOINES UNIVERSITY
MEDICINE & HEALTH SCIENCES
Center for Educational Enhancement – Academic Support • accommodations@dmu.edu • 515-271-1516

VERIFICATION OF PSYCHOLOGICAL DISABILITY

Student completes this section

I am requesting academic support services through the Center for Educational Enhancement – Academic Support at Des Moines University. They require current and comprehensive documentation of my psychological condition as one of the criteria used to evaluate my eligibility for disability related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to CEE C/O Accommodations and Educational Support Specialist by email at accommodations@dmu.edu. I authorize the Accommodations and Educational Support Specialist at DMU to contact you if clarification is needed.

Student name: _____ Birthdate: _____

Student Signature: _____ Date: _____

Mental Health Provider section

Provider name (print): _____Title _

Phone: _____ Fax: _____

Organization name: _____

Organization address: _____

Is the individual **currently** in treatment with you? If so, when did you last see him or her? Note: As per DMU policy, it is required that a student is **reevaluated at least every year** for a Psychological Disability.

Please list the diagnoses as listed in the DSM-5-TR with the principal diagnosis listed first and others following in order of importance to treatment:

What were the assessment or evaluation procedures used to make the diagnosis?

What historic data was taken into account in making the diagnosis?

What medications are prescribed currently? List any side effects and level of severity.

Please indicate the major symptoms and severity level of the disorder currently manifested by the student:

Symptom	Mild	Moderate	Severe
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐

What is the **prognosis and anticipated duration**?

What are the current limitations imposed by this disorder?

What are your recommendations for accommodations and why are they necessary?

Treatment Provider's Signature: _____ Date: _____

License #: _____

Attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).