University of Massachusetts Lowell
Learning with Purpose

Wellness Center, University Crossing
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DISABILITY SERVICES

Psychological Disability Verification Form

The student named below has applied for services from Student Disability Services (SDS) at UMass Lowell. To determine eligibility and to provide services, we require documentation of the student's psychological disability.

Under the Americans with Disabilities Act as amended and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please print it, sign it, and email or fax it to us at the address in our letterhead. The information you provide will not become part of the student's educational records but will be kept in the student's file at SDS, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant. Please contact us if you have questions or concerns. Thank you for your assistance.

RELEASE OF INFORMATION

I, _____ hereby authorize the release of the following information to the Office of Disabilities Services at University of Massachusetts Lowell for the purpose of determining my eligibility for academic accommodations.

Student ID #: _____ Date: _____

Signature: _____

TO BE COMPLETED BY LICENSED PROVIDER

What is your DSM V or ICD-10 diagnosis(es) for this student? _____

_____

_____

_____

Date of above Diagnosis(es): _____

Date last seen: _____

In addition to DSM V or ICD-10 criteria, how did you arrive at your diagnosis(es)?
Please check all relevant items below and attach brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.

- ☐ Structured or unstructured interviews with student
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history
- ☐ Neuropsychological testing. Date(s) of testing: _____
- ☐ Psycho educational testing. Date(s) of testing: _____
- ☐ Standardized or non-standardized rating scales.
- ☐ Other (Please specify): _____

Major Life Activities Assessment:

- *Please check which of the following major life activities listed below are affected because of the diagnosis. Please indicate severity of limitations*.

Life Activity	**No Impact**	**Minor Impact**	**Moderate Impact**	**Substantial Impact**
Caring for oneself	○	○	○	○
Talking	○	○	○	○
Hearing	○	○	○	○
Breathing	○	○	○	○
Seeing	○	○	○	○
Walking/Standing	○	○	○	○
Lifting Carrying	○	○	○	○
Sitting	○	○	○	○
Performing Manual Tasks	○	○	○	○
Eating	○	○	○	○
Working	○	○	○	○
Learning	○	○	○	○
Reading	○	○	○	○
Writing/Spelling	○	○	○	○
Calculating	○	○	○	○
Memorizing	○	○	○	○
Concentrating	○	○	○	○

Life Activity	No Impact	Minor Impact	Moderate Impact	Substantial Impact
Listening	○	○	○	○
Other: _____	○	○	○	○

Medication prescribed: ☐ Yes ☐ No If yes, what? _____

_____

If so, by whom? _____

Frequency of monitoring: _____

How will refills be obtained? _____

Effect on academic functioning and side effects: _____

Do limitations/symptoms persist even with medications? ☐ Yes ☐ No

Has the student been hospitalized in the past year in relation to the above diagnosis(es)?
☐ Yes ☐ No

How long do you anticipate the student's academic achievement will be impacted by this diagnosis(es)? ☐ Six months ☐ One year ☐ One year +

What other specific symptoms is the student experiencing that might affect the student's academic performance?

_____

_____

_____

Please attach any information you have on learning disability testing, intellectual functioning, and/or academic problems which you feel we should know in order to help this student.

Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the address shown on the letterhead or to the student.

LICENSED PROVIDER INFORMATION*
(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider's Name: _____

License Number: _____

Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

**Examples of qualified professionals are licensed psychologists, psychiatrists, neurologists, licensed mental health providers, PCPs or NPs with knowledge of functional limitations. The diagnosing professional must have expertise in the differential diagnosis of the documented psychological diagnosis(es) or condition and follow established practices in the field.*