ACCESSIBILITY RESOURCE CENTER

WILLIAM PATERSON UNIVERSITY
300 Pompton Road, Speert Hall, Room 134
Wayne, NJ 07470
Phone (973)720-2853 Fax (973) 720-3293
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PSYCHOLOGICAL DISABILITY
DOCUMENTATION FORM

Student's Name: _____

The student named above is applying for disability accommodations and/or services through the Accessibility Resource Center (ARC) at William Paterson University. In order to determine eligibility, a qualified professional must certify that the student has a psychological diagnosis and must provide evidence that it represents a substantial impediment to a major life activity. It is important to understand that a diagnosis in and of itself does not substantiate a disability. In others words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. This documentation form was developed as an alternative to a traditional diagnostic report. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the ARC website. ARC expects the following in regard to this documentation form:

- The form will be completed with as much detail as possible as a partially completed form or limited responses will hinder the eligibility process.
- Assessment information that is more than two years old may be considered out of date depending on such factors as the student's current age, student's age at time of assessment and the nature of the diagnosis.
- The form is being completed by a professional who has comprehensive training and direct experience in the differential diagnosis such as a psychologist, psychiatrist, or certified social worker.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

What is the DSM-V diagnosis for this student?

_____

_____

_____

How long has the student had this diagnosis/condition? _____

What is the severity of the condition? ____ Mild ____ Moderate ____ Severe
Explain the severity indicated above: _____

_____

_____

What is the expected duration? ____ Chronic ____ Episodic ____ Short-term

Explain the duration indicated above: _____

Date of first contact with student: _____ Date of last contact with student: _____

Date(s) current psychological assessment completed: _____

Frequency of appointments with student (e.g., once a week, twice a month): _____

Psychological History – Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable): _____

Pharmacological History – Provide pertinent pharmacological history, including an explanation of the extent to which the medication has mitigated the symptoms of the disorder in the past:

Psychosocial History – Provide pertinent information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risktaking or dangerous activities, etc.):

What are the student's current symptoms and concerns? _____

Explain how the symptoms related to the student's disorder cause **significant impairment** in a **major life activity** (e.g., learning, eating, walking, interacting with others, etc.) in a classroom setting, if applicable.

Activity	No Limitation	Moderate Limitation	Substantial Limitation	Don't Know
Attention to detail/accuracy of work				
Sustaining attention				
Listening comprehension				
Completing tasks independently				
Sustained mental effort				
Organization				
Distractibility				
Memory				
Restlessness				
Impulsiveness				
Time management				
Mathematics				
Reading				
Writing				
Other (please specify)				

Provide information regarding the symptoms that cause impairment in **two or more settings** (e.g., work, home, or school etc.), if applicable: _____

_____

_____

_____

List the student's current medication(s), including dosage, frequency, and adverse side effects:

_____

_____

_____

Are there significant limitations to the student's functioning directly related to the prescribed medications? ____ Yes ____ No

If yes, explain: _____

_____

_____

_____

Provide an explanation of the extent to which the medication currently mitigates the symptoms of the disorder: _____

_____

State the student's functional limitations from the disorder specifically in a classroom or educational setting: _____

State specific recommendations regarding academic adjustments, housing accommodations, auxiliary aids, and/or services for this student and the reason these academic adjustments, housing accommodations, auxiliary aids, and/or services are warranted based upon the student's functional limitations: _____

If current treatments (e.g., medications, counseling) are successful, state the reasons the above academic adjustments, housing accommodations, auxiliary aids, and/or services are necessary?

Certifying Professional

Name and Title

License or Certification #

Company/Office/Institution Affiliation Name

Address

Phone #

City, State, Zip

Fax #

Signature of Certifying Professional

Date

Please Return To:
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