

To be completed by the student's evaluator
and then returned to the Office of Disability
Services

Lewis-Clark
S T A T E
C O L L E G E

Office of Disability Services

111 Reid Centennial Hall

500 8th Avenue

Lewiston, ID 83501

Office: 208-792-2211

Fax: 208-792-2453

www.lcsc.edu/osl/ada.htm

**REQUEST FOR DISABILITY
VERIFICATION OF A PSYCHOLOGICAL
AND/OR PSYCHIATRIC DISORDERS**

To ensure the provision of reasonable and appropriate services for students with mental illness, the Office of Disability Services requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential. Thank you for your assistance in this matter.

Student's Name: _____

1. DSM-IV Diagnosis: Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

2. Date of original diagnosis, plus update of the diagnosis if diagnostic report is older than 6 months.

3. Summary of symptoms and test findings which support the diagnosis, including any results from testing. Please include: 1) history of presenting symptoms; 2) duration and severity of the disorder; and 3) relevant developmental, historical and familial data.

4. Describe the student's current functional limitations in an educational setting:

5. Is this student currently on medication(s), or have they ever taken medication(s), that may affect their academic achievement? If so, provide relevant information about their medication history:

6. If the student was previously identified as disabled, describe the services provided.

7. (Optional) Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for accommodations that you believe will help equalize the student's ability to access the Lewis-Clark State College's educational program. Please indicate your rationale for the requested accommodations.

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above and that I am a licensed psychologist, neuro-psychologist, psychiatrist, other relevantly trained medical doctor, or counseling professional.

Signature: _____ Date: _____

Print Name and Title: _____

Area of Specialty: _____

State License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____