

LCSC Accessibility Services 500 8th Avenue Library, Room 161 Lewiston, ID 83501 Phone: 208.792.2677 Fax: 208.792.2143 accessibilityservices@lcsc.edu www.lcsc.edu/accessibility-services

Mental Health Verification Form

REQUEST FOR DISABILITY VERIFICATION OF A MENTAL HEALTH DISORDER

Anxiety Disorders, Major Depressive Disorder, Bipolar Disorder, Impulse-Control Disorder, etc.

Form is to be completed by the student's evaluator and then returned to Accessibility Services.

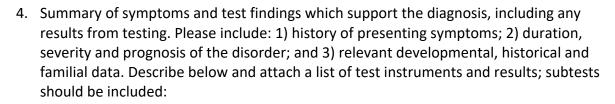
To ensure the provision of reasonable and appropriate services for students with a mental health disorder, the Accessibility Services office requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential.

Student Information

Studei	nt Name:
1.	DSM-5 Diagnosis (ICD-10 Code)
2.	Date of original diagnosis
	Please include any evidence of early impairment, whether or not the student received treatment:
3.	Date of most recent evaluation(documentation should be current, within the last 3-5 years; include update of the
	diagnosis if diagnostic report is older than 6 months)

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5. Describe any treatment plan(s) including a description of the student's responsibility.

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6.	Describe the student's current functional limitations in an educational setting:
7.	Is this student currently on medication(s) that may affect their academic achievement? If so, provide relevant information about their medical history:
8.	Please provide your specific recommendations (based on 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.

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Evaluator Information

diagnostic assessment of the student nam	relevantly trained medical doctor or counseling
Print Name:	
Title:	
Area of Specialty:	
State License(s):	
License Number(s):	
	Fax:
Signature:	
For Office Use Only	
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Accessibility Services Staff (Full Name):	

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