CLAYTON STATE UNIVERSITY
Disability Resource Center

Documentation for Psychological Disorders

Clayton State University's Disability Resource Center provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. The Disability Resource Center will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. All parts of this form must be completed as thoroughly and legibly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process for the student.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in the Disability Resource Center. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic needs.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Resource Center staff at Clayton State University.

To view the USG BOR disability documentation criteria, please visit the following website: https://www.usg.edu/academic_affairs_handbook/section3/C793.

_____	_____	_____
Date	Student Name (Print)	Student ID#

Primary Diagnosis: _____

DSM/ICD code: _____ Date of onset: _____

Additional Diagnosis: _____

DSM/ICD code: _____ Date of onset: _____

Date of last visit: _____ Frequency of office visits: _____

Describe the history, current symptoms and severity of the condition.

_____

_____

_____

_____

Describe the functional limitations which affect this student in the academic setting, and give suggestions for accommodations.

Limitations	**Recommendations**

List current medications, relevant side effects, and explain how each impacts the individual's limitations.

Medication/Dosage	**Side Effects**	**Impact on Limitations**

Describe the expected progression, duration, and stability of the condition(s). (*Add pages if needed*.)

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License #: _____

[Attach Business Card Here]