TEXAS A&M UNIVERSITY
CORPUS CHRISTI

Disability Services
6300 Ocean Drive, Unit 5717
Corpus Christi, Texas 78412-5717
Office: 361-825-5816 · Fax: 361-825-2536

# PSYCHOLOGICAL DISABILITY VERIFICATION FORM

## I. Student Information

Name _____ Student ID# _____

Address _____

Phone _____ Date of Birth _____

I request and authorize the release of the information provided on this Disability Verification Form to the Disability Services Office at Texas A&M University-Corpus Christi.

_____ _____
Student Signature Date

The following information **MUST** be:

- Completed by a **qualified professional**, including Licensed Psychologist, Counselor, Psychiatrist, Physician. The diagnosing professional must not be related to the student.
- Completed as **clearly and thoroughly**, as possible. Incomplete responses may not provide sufficient information in order for this form to stand as the sole form of documentation to support reasonable academic accommodations.
- Submitted to the Disability Services office at Texas A&M University-Corpus Christi. All documentation is considered confidential and released to the student, upon request.

## II. Diagnosis (DSM-5 or ICD 10)

| | Name | Code (DSM-5) | Code (ICD-10) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Date diagnosed:** _____

**Date of last clinical contact with student:** _____

**Severity of symptoms (current):**
☐Mild ☐Moderate ☐Severe

***Approximate* onset of condition:**
☐Child (age:_____) ☐Adolescent (age:_____) ☐Adult (age: _____) ☐Unknown

**What sources of information did you consider in making this determination/diagnosis?** Please check all relevant items below, adding any notes that you think might be helpful to us as we determine accommodations.

☐Clinical Interview (structured or unstructured)
☐Developmental History/Interview(s) with other persons (e.g., parent, teacher, therapist)
☐Behavioral Observation(s)
☐Psychoeducational Assessment (attach document)
☐Psychological Assessment (attach document)
☐Other (please specify): _____

## III. Impact of Disability

**Does this condition interfere with one or more of the following major life activities?**

| | | |
|---|---|---|
| ☐caring for self | ☐performing manual tasks | ☐walking |
| ☐seeing | ☐hearing | ☐speaking |
| ☐breathing | ☐learning | ☐working |
| ☐eating | ☐sleeping | ☐standing |
| ☐lifting | ☐bending | ☐reading |
| ☐concentrating | ☐thinking | ☐communicating |
| ☐other: | ☐other: | ☐other: |

**Describe the functional limitations and any other factors that may impact the student in an educational setting** (e.g., easily distracted, poor concentration, difficulty focusing for extended periods of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations)**:**

_____

_____

_____

_____

_____

_____

_____

_____

## IV. Certification by Qualified Professional

_____
Name (Typed or Printed) Signature

Address _____

City _____ State _____ Zip _____

Date _____ License Number _____