Psychiatric Disability Verification Form
East Carolina University
Disability Support Services
dssdept@ecu.edu, fax: 252-737-1025,    252-737-1016

Student Information

Name: __________________________________________________________________
Date of Birth: ________________________  Student ID: ____________________

The following information needs to be filled out by a qualified provider. Please provide responses to the
following items by typing or writing clearly. Illegible forms will delay the documentation review process
for the student.

Provider Information

Provider Signature: ________________________________ Date: _______________
Provider Name (print): __________________________________________________
Title: ________________________________________________________________
Address: _____________________________________________________________
Phone: (_____) _____________________  Fax: (____) ________________________

1. Date of Diagnosis: ______________________________________________

2. Date student was last seen: _______________________________________

3. DSM-V Diagnosis
____________________________________________________________________
____________________________________________________________________

4. If a psycho-educational evaluation was completed, please include with this form.

5. What is the expected duration of this disability? _________________________________

6. Is the student currently taking medications? If so, how might side effects, if any, affect the
student’s academic performance?
Major Life Activities: Please check which of the following major life activities are affected and the degree to which they impact the student.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentrating</td>
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</tr>
<tr>
<td>Memory</td>
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<tr>
<td>Eating</td>
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<tr>
<td>Sleeping</td>
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<tr>
<td>Self Care</td>
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<tr>
<td>Social Interactions</td>
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<tr>
<td>Ability to Pay Attention</td>
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<tr>
<td>Attending Class Regularly</td>
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<tr>
<td>Managing internal distractions</td>
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<tr>
<td>Managing external distractions</td>
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<tr>
<td>Stress Management</td>
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<tr>
<td>Organization</td>
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<td>Attending to Tasks</td>
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<tr>
<td>Putting Thoughts to Words</td>
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<tr>
<td>Motivation</td>
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</tbody>
</table>

7. Please describe symptoms relating to this diagnosis that may affect the student’s academic performance and/or housing accommodations.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

8. Please state specific recommendations regarding academic accommodations for this student.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

9. Are there other associated disabilities? If so, what are they? Please describe these conditions and any functional limitations.

_________________________________________________________________________________

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