



**DISABILITY VERIFICATION FORM  
TO BE COMPLETED BY THE PSYCHIATRIST/PSYCHOLOGIST/DIAGNOSING PHYSICIAN**

Eligibility requirements for support services for students with disabilities:

1. Student provides verification of diagnosis and severity.
2. Student is assessed as having a functional limitation in the educational setting.

To ensure provision of reasonable and appropriate services for students with disabilities, students needing such services are required to provide current and comprehensive documentation of their disability. This documentation should include information which diagnoses the disability, describes the difficulties and functional limitation in an educational setting, indicates the severity and longevity of the condition, and offers recommendations for treatment. To facilitate the gathering of such critical information, we ask that you respond to the following questions:

Please provide the following information about:

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*(Print student's name)*

1. Diagnosis: \_\_\_\_\_  
*(Include DSM code for all mental disabilities)*

2. Level of severity (check one):       mild       moderate       severe

3. Date of diagnosis: \_\_\_\_\_

4. Describe the procedures used to assess/diagnose:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach diagnostic report (Learning disability evaluation/psychological testing information and results.)

5. Describe symptoms which meet the criteria for this diagnosis with approximate date of onset, if appropriate:  
\_\_\_\_\_  
\_\_\_\_\_

6. Describe this student's functional limitations in an educational setting:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What measures were used to assess current educational achievement?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Do you have any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Describe services/accommodations in exam administration, classroom or study activities, or course requirements.)

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9. Provide a medication history related to this disability.

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10. Could the medication interfere with student's ability to achieve academically?

Yes \_\_\_\_\_

No \_\_\_\_\_

11. In addition to the diagnostic report, please attach other information relevant to this student's academic adjustment.

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Signature: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

License/Certification Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this completed form to: Anne Arundel Community College  
Counseling, Advising and Retention Services  
Disability Support Services/SSVC 200  
101 College Parkway  
Arnold, MD 21012  
410-777-2306 ♦ FAX: 410-777-4070

**Notice of Nondiscrimination**

AACC is an equal opportunity, affirmative action, Title IX, ADA Title 504 compliant institution. Call Disability Support Services, 410-777-2306 or Maryland Relay 711, 72 hours in advance to request most accommodations. Requests for sign language interpreters, alternative format books or assistive technology require 30-day notice. For information on AACC's compliance and complaints concerning discrimination or harassment, contact Karen L. Cook, Esq., federal compliance officer, at 410-777-7370 or Maryland Relay 711.