

Rutgers
The State University of New Jersey

Office of Disability Support Services
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www.disabilityservices.rutgers.edu

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 151 College Avenue
 New Brunswick, NJ, 08901
 Phone # 732-932-2848
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DOCUMENTATION OF PSYCHOLOGICAL DISABILITY

The student named below has applied for services from the Office of Disability Support Services (DSS) at Rutgers University. In order to determine eligibility and to provide services, we require documentation of the student's psychological disability.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please return to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

Student's Name: _____

Today's Date: _____ Date of diagnosis below: _____

Date Student was Last Seen: _____

DSM-IV Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (GAF score): Present time: _____ Average over last year: _____

3. What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

4. What medications is the student currently taking? How effective is the medication? How might side-effects, if any, affect the student's academic performance?

5. What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

**6 Months 1 Year More
than 1 year**

Check one:

6. Is there anything else you think we should know about the student's psychological disability?

CERTIFYING PROFESSIONAL*

Role of the person completing this form (check all that apply):

Treating professional: Psychotherapy Medication supervision Other _____
 Evaluator: _____ 2nd Opinion Evaluator: _____
 Other: _____

Printed Name: _____ Signature: _____

License Number: _____ Profession: _____

Address: _____

Telephone: _____ Fax: _____