



University of South Carolina Upstate  
800 University Way, CLC 107  
Spartanburg, SC 29303  
864-503-5199  
Fax: 864-347-3328

## Psychiatric Disability Verification Form

The student named below has applied for academic accommodations through Disability Services at USC Upstate. In order to determine eligibility, we require current and comprehensive documentation of the student's disability.

Under the ADA Amendments Act of 2008 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. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please return it to the student or, with the student's permission, you may return it to our office. The information you provide will be held confidential and will not become part of the student's educational records. In addition to the requested information, please attach any reports which provide additional related information. Please contact us at 864/503-5199 or email Disability Services at [DSINFO@uscupstate.edu](mailto:DSINFO@uscupstate.edu) if you have any questions or concerns. Thank you for your assistance.

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### Consent For External Release of Information

I, \_\_\_\_\_, authorize \_\_\_\_\_ to release to Disability Services at the University of South Carolina Upstate any and all information that is relevant to my disability, the functional limitations imposed by my disability and any recommendations of possible accommodations including, but not limited to, the information in the attached form.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. Student's Name (Last, First, Middle): \_\_\_\_\_

2. DSM-V diagnosis for this student \_\_\_\_\_

3. Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Initial Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Approximate date of onset? \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Date student was last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. What is the severity of the disorder? \_\_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Severe

Please describe the severity checked above:

\_\_\_\_\_

6. Is the impairment chronic or acute, cyclical or episodic, or in partial or full remission?

\_\_\_\_\_

7. Please check which of the major life activities listed below are significantly affected as a result of his/her medical condition. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Caring for Oneself				
Eating				
Sleeping				
Speaking				
Learning				
Concentrating				
Thinking				
Communicating				
Memory				
Social Interactions				
Attending Class Regularly and On Time				
Managing and Keeping Appointments				
Stress Management				
Organization				
Attention				

8. Please describe the student's current symptoms relating to this diagnosis:

\_\_\_\_\_

9. State the student's functional limitations (challenges for academics arising from the condition) based on the psychiatric diagnosis, specifically in a post-secondary environment:

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10. Is the student currently receiving therapy or counseling? If so, how often and with whom?

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11. Is the student currently taking medications for these symptoms? If so, please describe the medications, date prescribed, effect on functioning, and possible adverse side effects.

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12. Please state specific recommendations regarding academic accommodations for this student and provide your rationale for these recommendations.

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13. Is there anything else you think we should know about this student's psychiatric disability?

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14. Describe any referrals for additional psychiatric testing/evaluation for this student:

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**Certifying Professional:**

\_\_\_\_\_  
Signature of Professional

\_\_\_\_\_  
Date

\_\_\_\_\_  
Professional's Name (Printed) and Title

\_\_\_\_\_  
Name of Practice

\_\_\_\_\_  
Professional Credentials

\_\_\_\_\_  
License or Certification No.

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Fax

**Disability Services**  
Division of Student Affairs  
University of South Carolina Upstate  
800 University Way, CLC 107, Spartanburg, SC 29303  
864-503-5199 or email Disability Services at [DSINFO@uscupstate.edu](mailto:DSINFO@uscupstate.edu)