



## CERTIFICATION OF EMOTIONAL/MENTAL DISABILITY

The student named below has applied for services from the Disabled Student Services (DSS) at Lake City Community College. In order to determine eligibility and to provide services under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, we require documentation which indicates that a specific disability exists and that the identified disability substantially limits one or more major life activities. The documentation must also support the requested accommodations and academic adjustments.

After completing this form, please mail or FAX it to us at the address at the end of the form. The information you provide will be kept in the student's file at DSS, where it will be held strictly confidential. In addition to the information you provide on the form, attach any other information you think would be helpful to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

**Date:** \_\_\_\_\_ **Name of Student** \_\_\_\_\_

I grant permission for my medical/mental health provider to release (copies of) information regarding my disability, the diagnosis, treatment and accommodation recommendations to the Office of Disabled Student Services at Lake City Community College.

**Signature** \_\_\_\_\_

Date of Diagnosis (below): \_\_\_\_\_ Student was last seen \_\_\_\_\_

DSM-IV diagnosis:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V (GAF score): \_\_\_\_\_

1. In addition to DSM-IV criteria, how did you arrive at your diagnosis? Please check all relevant items below, *adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.*

Structured or unstructured interviews with the person himself or herself.

Interviews with other persons.

Behavioral observations.

Developmental history.

Educational history.

Medical history.

Neuro-psychological testing. Date(s) of testing?

Psycho-educational testing. Date(s) of testing?

Standardized or un-standardized rating scales.

Other (Please specify).

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2. Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely submission of assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending class regularly and on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making and keeping appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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\***

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

License Number: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

*\*Qualified diagnosing professionals are licensed psychologists, psychiatrists, neurologists, clinical social workers, marriage and family therapists, and in some instances general practice physicians. The diagnosing professional must have expertise in the differential diagnosis of the documented mental disorder or condition and follow established practices in the field.*

When completed, please mail or fax this form to:

Disabled Student Services  
Lake City Community College  
149 SE College Place  
Lake City, FL 32025  
FAX: 386-754-4715