MALONE UNIVERSITY
CHRIST'S KINGDOM FIRST

DISABILITY VERIFICATION

Psychological & Psychiatric Disabilities

(to be completed by diagnosing/current psychiatrist or psychologist)

Please read the following prior to completing this form:

The Center for Student Success at Malone University provides support services to students with diagnosed disabilities, including psychological and psychiatric disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires current and comprehensive documentation of the disorder from their diagnosing/current physician. This should include information that describes the symptoms of the disorder, medication prescribed, and recommendations for treatment.

Please note that eligibility for services is determined based on a review of this information, in accordance with criteria established in the codification of *Section 504 of the Rehabilitation Act of1973,* and in cases pertaining to the *Americans with Disabilities Act.* It is therefore imperative that comprehensive information be provided so that Malone University can make an appropriate determination about the student's eligibility to receive disability-related accommodations under the law. Confidentiality of the information provided is ensured, and will in no way become part of the student's academic record. Please feel free to contact the Center for Student Success with any questions or concerns you might have regarding the information you are being asked to provide. Thank you for your assistance.

Please provide the following information about: _____

1. DSM-IV Diagnosis: _____

   Date of Diagnosis: _____

   Last contact with student: _____

2. Describe the symptoms associated with this disorder and the student's prognosis:

_____

_____

_____

_____

3. Describe how this disorder may affect this student in the college academic environment:

_____

_____

_____

4. List current medication, dosage, frequency and possible adverse side effects: _____

_____

_____

_____

_____

5. List any recommendations for accommodations in an academic setting that you have for this student (i.e. extra time on tests, distraction-free testing space, etc.): _____

_____

_____

_____

_____

6. Describe any specific concerns you may have, or other ways that we may be of further assistance to this student: _____

_____

_____

_____

Psychiatrist/Psychologist Signature: _____

Date: _____

Printed Name and Title: _____

Address: _____

_____

Phone: ( ) _____

E-mail address (if applicable): _____

Please mail or fax this form to:

Center for Student Success
Malone University
2600 Cleveland Ave. NW
Canton, OH 44709

Phone: 330/471-8496
Fax: 330/471-8390