GUIDELINES FOR DOCUMENTATION FOR PSYCHIATRIC/PSYCHOLOGICAL DISORDERS

The following information will assist the ODS staff in collaborating with the student to determine appropriate accommodations. Documentation serves as a foundation that legitimizes a student’s request for accommodations under the Americans with Disabilities Act.

A diagnosis by a licensed mental health professional (including licensed clinical social workers, licensed professional counselors, psychologists, psychiatrists and neurologists). This professional must be an impartial individual who is not a family member of the student.

Following FERPA, information submitted will become an educational record and can be released to the student named below upon his/her request.

Name of Student:_________________________________________ Date of Birth:________________________

1. Please provide a clear statement of the disability, including the DSM-IV diagnosis, date of last appointment and a summary of present symptoms:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

2. Describe the current impact of the psychiatric/psychological disability has on the student’s functioning and the limitations of the disability on learning or other major life activities:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Office of Disability Services
320 N. DuPont Hwy., New Castle, DE 19720
(302) 356-6937 Fax (302) 328-7376
www.wilmu.edu/studentlife/disabilityservices
3. Please provide medical information relating to the student’s needs, including current medication/dosages and the impact of medication on the student’s ability to meet the demands of the postsecondary environment:

Additional Information/Comments:

Signature of Medical Professional: ______________________________ Date:__________________________

Please PRINT name of professional and credentials: ______________________________

Address: ____________________________________________________________________________

Phone: __________________________

NOTE: Further assessment by an appropriate professional may be required if co-existing learning disabilities or other disabling conditions are indicated.