Academic Services
100 College Drive
Allentown, PA 18104
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Verification Form for Mental Health Conditions

Cedar Crest College's Disability Resources office has developed the Verification Form for students with mental health conditions to obtain current and thorough information from a qualified practitioner (Psychiatrist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor), **who has diagnosed a psychological/psychiatric condition and who has an established, on-going, therapeutic relationship with the student.**

The practitioner must complete this form; it should not be completed by other staff members at the practice or by the student. The practitioner must be licensed to practice in Pennsylvania or the state of the student's permanent residence and may not be a relative of the student.

Student Name (Last, First):

Date of Birth:

CCC ID Number:

PROVIDER COMPLETED INFORMATION

STUDENT CONTACT

Date of initial contact with student:

Date of **last three (3)** contacts with student:

Frequency of appointments (ex. once a week, once a month):

DIAGNOSIS/DIAGNOSES

Please include all pertinent diagnoses using DSM V codes. Please be specific with regard to the diagnosed disorder and list from most significant or limiting to least significant or limiting.

Please list procedures and assessments used to diagnose this student's condition(s):

1. Clinical Diagnosis:_____Date of Diagnosis: _____

DSM Code: _____ What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

What are the functional limitations and/or symptoms of this condition?

How long is this condition likely to persist? (please provide a specific answer): _____

2. Clinical Diagnosis:_____Date of Diagnosis: _____

DSM Code: _____ What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

What are the functional limitations and/or symptoms of this condition?

How long is this condition likely to persist? (please provide a specific answer): _____

3. Clinical Diagnosis:_____Date of Diagnosis: _____

DSM Code: _____ What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

What are the functional limitations and/or symptoms of this condition?

How long is this condition likely to persist? (please provide a specific answer): _____

What exacerbates the student's condition(s)?

Does the student have "flare-ups"? If so, how often do flare-ups occur (weekly, monthly, several times per _____, etc.), how do the student's symptoms change during a flare-up, how long do the flare-ups generally last?

FUNCTIONAL IMPACT

How does the student's condition(s) impact their ability to learn, meet the demands of the higher education setting, and/or live in College housing? **Please be specific.**

RECOMMENDED ACCOMMODATIONS

Please identify any accommodations you believe may be necessary for this student to **equally participate in and have access to** the College's programs, activities and services. Please explain how each accommodation may ameliorate the student's limitations related to their diagnosed condition(s).

PROVIDER'S CERTIFICATION & PROFESSIONAL INFORMATION

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor).

☐ **I certify, as the direct treating provider, that I have personally completed this form.**

Provider's Name:

License Number: State of Licensure:

Practice Name:

Street Address:

City: State: Zip Code:

Phone Number:

Provider Signature:

Date Completed:

SUBMITTING THIS FORM

Please mail the original signed copy of this form to:

Susan Barnes, MS, CRC
Director of Learning and Disability Resources
Cedar Crest College
100 College Drive
Allentown, PA 18104-6196