

**The University of Tennessee- Knoxville**  
**Office of Disability Services**  
**2227 Dunford Hall**  
**Knoxville, TN 37996**  
**(865) 974-6087 v/t (865) 974-9552 fax**

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**Certification Form for Psychological Disabilities**

The student named below has applied for services from the Office of Disability Services at The University of Tennessee. In order to determine eligibility and to provide services, we require documentation of the student's psychological disability.

Under the Americans with Disabilities Act (ADA) of 1990 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 limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please mail it to us at the address listed above. The information you provide will not become part of this student's educational records, but will be kept in the student's file at ODS, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have any questions or concerns. Thank you for your assistance.

**To Be Completed by the Student's Evaluator**  
**Please write legibly or type**

Student's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Date Student was Last Seen: \_\_\_\_\_

**DSM IV Diagnosis and Code:**

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

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

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

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

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

1. In addition to the 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 | <input type="checkbox"/> | Medical History                             | <input type="checkbox"/> |
| Interviews with other persons         | <input type="checkbox"/> | Neuro-psychological testing?<br>dates:_____ | <input type="checkbox"/> |
| Behavioral Observations               | <input type="checkbox"/> | Psycho-educational testing<br>dates:_____   | <input type="checkbox"/> |
| Developmental History                 | <input type="checkbox"/> | Rating scales                               | <input type="checkbox"/> |
| Educational History                   | <input type="checkbox"/> | Other (please specify):_____                | <input type="checkbox"/> |

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

	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?

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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?

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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?

*Circle one:*                      6 months                                      1 year                                      more than 1 year

6. Is there anything else you think we should know about the student's psychological disability?

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**Certifying Professional**

Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_

State of License and Number: \_\_\_\_\_

Address (complete): \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

All materials must be signed and dated. By doing so, the Evaluator certifies that they are an appropriately licensed professional; have been trained in psychiatric, psychological, or neuropsychological assessment; and have at least three years experience in the evaluation of individuals with psychiatric disabilities.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date