Services for Students with Disabilities (SSD)
232 Canfield Administration Building
P.O. Box 880401
Lincoln, NE 68588-0401

Phone: (402) 472-3787
Fax: (402) 472-0080

Verification Form for Mental Health Disabilities

The University of Nebraska Lincoln (UNL) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equal access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a mental health condition, in and of itself, does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

The Office of Services for Students with Disabilities (SSD) strives to insure that qualified students with Mental Health Disabilities are accommodated and, if possible, that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a Mental Health Disability should have this form filled out by a doctor, psychiatrist, licensed psychologist, certified social worker (CSW or ACSW) or licensed professional counselor. The professional completing this form must have first-hand knowledge of the student's condition, must have experience diagnosing and treating college students, and will be an impartial professional who is not related to the student.

This form is not the only part of this process. Equally and sometimes more important will be your interview with SSD staff. Ideally this would happen before you begin attending class.

Student Information (This section to be completed by the student)

Last Name: _____ First Name: _____ Middle Initial: ____

ID Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Certifying Professional

Name: _____ Credentials:_____

Address: _____ City: _____ State: ____ Zip Code: _____

License/Certification number and state of licensure: _____

Years of experience working with college students: _____

Date of initial contact with student: _____ Date of last contact with student: _____

DSM V diagnosis: _____ Date of Diagnosis: _____

Basis on which diagnosis was made: _____

If psychological tests were used please include all scores used to support the diagnosis:

_____

If the diagnosis includes a phobic response to exams, does the problem pose a substantial limitation to the student demonstrating their knowledge of the class material on an unaccommodated exam? Yes_____ No _____

Explanation: _____

Current medications including dosage and side effects:

_____

Long term medication plan:_____

Current compliance with medication plan: _____

Prognosis for medication plan (Include likelihood of improvement or further deterioration and within what approximate time frame): _____

Planned therapeutic interventions:_____

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame):_____

Current compliance with therapeutic interventions: _____

History of hospitalization: _____

Implications for Educational Success

Learning abilities specific to the postsecondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.):

_____

Implications for taking exams and other classroom activities caused by the disorder or medications. Please specify which:

_____

Suggested accommodations (Final determination of appropriate accommodations will be determined by the SSD office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws). Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed.

Extension of time to complete exams: Yes ____ No ____
Why?_____

Quiet room in which to take exams: Yes ____ No ____
Why?_____

Other (please specify):
Why?_____

If you have any questions regarding the nature of the information needed for students with psychiatric impairments, please call Services for Students with Disabilities at (402) 472-3787, Monday through Friday from 8:00 A.M. to 5:00 P.M. Central Standard Time.

This form should be returned to 232 Canfield Administration Building, P.O. Box 880401, Lincoln, NE 68588-0401 or faxed to us at (402) 472-0080.

This document may not be released without written permission from the student or by order of a court. It will be destroyed three years after the student is no longer enrolled. The student will have access to this document but you may specify that this access be given when there is a person qualified to explain the document available.

Signature of Certifying Professional:_____ Date: _____