DISABILITY VERIFICATION
Psychological & Psychiatric Disabilities
(to be completed by diagnosing/current Psychiatrist, Psychologist, or LCSW)

Please read the following prior to completing this form:

Disability Support Services at Western Nevada College 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 psychiatrist or psychologist. 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 Section *504 of the Rehabilitation Act of 197*3, and in cases pertaining to the *Americans with Disabilities Act.* It is therefore imperative that comprehensive information be provided so that Western Nevada College Disability Specialists 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 Disability Support Services office with any questions or concerns you might have regarding the information you are being asked to provide. Thank you for your assistance.

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Please provide the following information about:
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1. DSM-IV Diagnosis:
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Date of Diagnosis:
____

Last contact with student:
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2. Describe the symptoms associated with this disorder:
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3. Describe how this disorder may affect this student in the college academic environment:
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4. List current medication, dosage, frequency and possible adverse side effects:
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5. List any recommendations for accommodations in an academic setting you have for this student (i.e. extra time for exams, distractions-free space, etc.):

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6. Please describe any specific concerns you may have or ways that we may be of further assistance to this student:

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Psychiatrist/Psychologist/LCSW Signature:_________________________
Date:____________

Printed Name and Title:____
Address:____
____
____
Telephone: (   )_______________________

Please mail or fax this form to:

Susan Trist, M.A., CRC
Western Nevada College
Disability Support Services
Bristlecone Building, Room 103
2201 West College Parkway
Carson City, NV 89703
Telephone: (775) 445-3268
FAX: (775) 445-3149