Psychological Disability Documentation Instructions and Form
Updated March 2024

Student Instructions and Information:

- Students must submit current documentation to the Office of Accessibility and Testing Services.
  - Current documentation is defined as:
    - Documentation that reflects data collected within three years at the time of request for services.
    - It is at the Accessibility and Testing Services Specialist's discretion to make appropriate exceptions to this policy and/or to request a reevaluation and more recent documentation in order to establish the most appropriate accommodations.
- A qualified provider (medical doctor, psychologist, or psychiatrist) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider’s practice. Any documentation must include the provider’s signature and credentials.
- Students are asked to provide documentation prior to the intake meeting if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed.
- For timely review of application, documentation must be submitted by the student requesting services via our secure portal, AIM located on our website. If you have any questions regarding this process, please email to accessibility-services@westga.edu.

To be Completed by Student:

Name (Last, First, Middle):__________________________________________________________

Date of Birth: ________________________________ UWG ID Number: 917___________________________

Cell Phone: ________________________________ Alternate Phone: ________________________________

Home Address: _____________________________________________________________________________
__________________________________________________________________________________________

Email Address: _____________________________________________________________________________

Status (Check One):   ____Current Student     ____ Transfer Student    ____ Prospective Student
To be Completed by Provider:

The Office of Accessibility and Testing Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see Appendices D-H of the USGBOR Academic and Student Affairs Handbook for more information.

Primary Diagnosis:________________________________________________________________________

DSM-5 Code:___________________________________Date of Diagnosis:____________________________

Secondary Diagnosis:________________________________________________________________________

DSM-5 Code:___________________________________Date of Diagnosis:____________________________

Please provide the diagnostic criteria and methodology used to diagnose the condition.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Please check any of the following as appropriate to describe the patient’s symptoms and/or behavioral manifestations.

___Feeling sad or down
___Confused thinking or reduced ability to concentrate
___Excessive fears or worries
___Extreme feelings of guilt
___Feelings of worthlessness or self-hate
___Extreme mood changes of highs and lows
___Withdrawal from friends and activities
___Significant tiredness, low energy
___Problems sleeping or excessive sleeping
___Detachment from reality (delusions), paranoia or hallucinations
___Inability to cope with daily problems or stress
___Trouble understanding and relating to situations and to people

___Other________________________________________________________________________________

Please check any of the following as appropriate to describe the patient’s symptoms and/or behavioral manifestations.

___Alcohol or drug abuse
___Major changes in eating habits
___Sex drive changes
___Excessive anger, hostility or violence
___Suicidal thinking
___Agitation, restlessness, and irritability
___Feelings of hopelessness and helplessness
___Heart palpitations
___Chest pain
___Rapid heartbeat
___Headaches
___Sweating
___Nausea/vomiting
___Tremors/shaking

___Other________________________________________________________________________________

___Other________________________________________________________________________________

___Other________________________________________________________________________________
Please describe the history and severity of the disorder.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Is it expected that the patient’s functioning and/or severity of the disorder will change over time?

_____Yes  _____No

If yes, please explain the anticipated progression.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Please check all of the following as appropriate to describe the patient’s functional limitations. This list of possible functional limitations is from the Center for Psychiatric Rehabilitation, 1997 (http://www.washington.edu/doit/what-are-some-functional-limitations-related-mental-illness).

_____Difficulty with medication side effects: side effects of psychiatric medications that affect academic performance include drowsiness, fatigue, dry mouth and thirst, blurred vision, hand tremors, slowed response time, and difficulty initiating interpersonal contact.

_____Screening out environmental stimuli: an inability to block out sounds, sights, or odors that interfere with focusing on tasks. Limited ability to tolerate noise and crowds.

_____Sustaining concentration: restlessness, shortened attention span, distraction, and difficulty understanding or remembering verbal directions.

_____Maintaining stamina: difficulty sustaining enough energy to spend a whole day of classes on campus; combating drowsiness due to medications.

_____Handling time pressures and multiple tasks: difficulty managing assignments, prioritizing tasks, and meeting deadlines. Inability to multi-task work.

_____Interacting with others: difficulty getting along, fitting in, contributing to group work, and reading social cues.

_____Fear of authority figures: difficulty approaching instructors and/or teaching/lab assistants.

_____Responding to negative feedback: difficulty understanding and correctly interpreting criticism or poor grades. May not be able to separate person from task (personalization or defensiveness due to low self-esteem).

_____Responding to change: difficulty coping with unexpected changes in coursework, such as changes in the assignments, due dates, or instructors. Limited ability to tolerate interruptions.

_____Severe test anxiety: such that the individual is rendered emotionally and physically unable to take the exam.

_____Other________________________________________________________________________________
Please provide any additional information/context as appropriate concerning the functional limitations.

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__________________________________________________________________________________________
__________________________________________________________________________________________

Please provide any recommendations to address the indicated functional limitations.

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__________________________________________________________________________________________
__________________________________________________________________________________________
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Please attach any psychological and/or educational reports that support the diagnosis and complete the following information:

Provider Name:_____________________________________________________________________________

Title:_____________________________________________________________________________________

License #:_________________________________________________________________________________

Practice Name and Address:___________________________________________________________________
__________________________________________________________________________________________

Phone:________________________________________ Fax:________________________________________

Email:____________________________________________________________________________________

Provider Signature (REQUIRED):________________________________________________________________

Date of Signature:___________________________________________________________________________