DISABILITY SERVICES
University of South Carolina Upstate
800 University Way, CLC 107
Spartanburg, SC 29303
864-503-5199
Fax: 864-347-3328

Psychiatric Disability Verification Form

The student named below has applied for academic accommodations through Disability Services at USC Upstate. In order to determine eligibility, we require current and comprehensive documentation of the student's disability.

Under the ADA Amendments Act of 2008 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 substantially limits one or more major life activities. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please return it to the student or, with the student's permission, you may return it to our office. The information you provide will be held confidential and will not become part of the student's educational records. In addition to the requested information, please attach any reports which provide additional related information. Please contact us at 864/503-5199 or email Disability Services at DSINFO@uscupstate.edu. if you have any questions or concerns. Thank you for your assistance.

Consent For External Release of Information

I, _____, authorize _____to release to Disability Services at the University of South Carolina Upstate any and all information that is relevant to my disability, the functional limitations imposed by my disability and any recommendations of possible accommodations including, but not limited to, the information in the attached form.

Student Signature: _____ Date: _____

1. Student's Name (Last, First, Middle): _____

2. DSM-V diagnosis for this student_____

3. Date of Diagnosis: _____/_____/_____ Date of Initial Diagnosis: _____/_____/_____

   Approximate date of onset? _____/_____/_____

4. Date student was last seen: _____/_____/_____

5. What is the severity of the disorder? _____ Mild _____ Moderate _____ Severe
   Please describe the severity checked above:
   _____
   _____

6. Is the impairment chronic or acute, cyclical or episodic, or in partial or full remission?
   _____
   _____

7. Please check which of the major life activities listed below are significantly affected as a result of his/her medical condition. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Caring for Oneself				
Eating				
Sleeping				
Speaking				
Learning				
Concentrating				
Thinking				
Communicating				
Memory				
Social Interactions				
Attending Class Regularly and On Time				
Managing and Keeping Appointments				
Stress Management				
Organization				
Attention				

8. Please describe the student's current symptoms relating to this diagnosis:
   _____
   _____

9. State the student's functional limitations (challenges for academics arising from the condition) based on the psychiatric diagnosis, specifically in a post-secondary environment:
   _____
   _____

10. Is the student currently receiving therapy or counseling? If so, how often and with whom?

    _____

    _____

11. Is the student currently taking medications for these symptoms? If so, please describe the medications, date prescribed, effect on functioning, and possible adverse side effects.

    _____

    _____

12. Please state specific recommendations regarding academic accommodations for this student and provide your rationale for these recommendations.

    _____

    _____

13. Is there anything else you think we should know about this student's psychiatric disability?

    _____

    _____

14. Describe any referrals for additional psychiatric testing/evaluation for this student:

    _____

    _____

Certifying Professional:

_____	_____
Signature of Professional	Date
_____	_____
Professional's Name (Printed) and Title	Name of Practice
_____	_____
Professional Credentials	License or Certification No.
_____	_____
Address	Telephone No.
_____	_____
City, State, Zip	Fax

Disability Services
Division of Student Affairs
University of South Carolina Upstate
800 University Way, CLC 107, Spartanburg, SC 29303
864-503-5199 or email Disability Services at DSINFO@uscupstate.edu

Revised 2/21/2019