Accessibility Services
Technology Center, Room 8150
845-574-4541

PSYCHOLOGICAL DISABILITY DOCUMENTATION REQUEST FORM

THIS FORM MUST CONTAIN ALL OF THE REQUESTED INFORMATION AND BE ***TYPED OR PRINTED*** IN ORDER TO APPLY FOR ACCOMMODATIONS THROUGH ACCESSIBILITY SERVICES

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Social Security Number: _____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Accessibility Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, College policy requires that **qualified professional** provide current and comprehensive documentation. A qualified professional is a licensed mental health professional. **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S STATEMENTS MUST BE WITHIN 1 YEAR PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM ACCESSIBILITY SERVICES.**

The documentation provided must include information that diagnoses a psychological disability (must make a DSM-5 diagnosis), describes the functional limitations in an educational setting, indicates the severity and longevity of the psychological disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication and any current side-effects which may impact academic performance.

To facilitate the gathering of such critical information, please respond to the following and return to RCC, Accessibility Services.

1. Diagnosis _____
2. Date of Diagnosis: _____

   Date of Last Contact with Student: _____

3. Provide a summary of the student's educational, medical, and family history that relates to the psychological disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):_____

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4. Describe the student's functional limitations in an educational setting:

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5. List current medication along with any current side-effects which may impact academic performance:

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6. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student's educational opportunities at RCC as justified based on the functional limitations indicated above:

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_____ _____

Signature of Qualified Professional Date

_____ _____

Qualified Professional's Name & Title (Printed) License #

_____ _____

Address Phone #

_____ _____

Fax

Please return this form to:

Accessibility Services, Room 8150
Rockland Community College
145 College Road
Suffern, NY 10901
Phone (845) 574-4541
Fax (845) 574-4594