NORTHEAST STATE COMMUNITY COLLEGE

Accessibility Services
2425 Highway 75, Blountville, TN 37617
Phone: (423)279-7640

PSYCHIATRIC/PSYCHOLOGICAL DISABILITY CERTIFICATION

The student named below has applied for service from the office of Accessibility Services at Northeast State. Northeast State provides academic services and accommodations to students with psychiatric/psychological disabilities. Students seeking services must provide appropriate medical documentation of their condition so that Accessibility Services can: 1) Determine the student's eligibility for accommodations, and 2) if the student is eligible, determine appropriate academic accommodations.

The Americans with Disabilities Act (ADA) defines disability as a "physical or mental impairment that substantially limits one or more major life activities, a record of such or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Documentation required to verify the student's condition and its severity, includes completion and return of this form to Accessibility Services by a professional with the appropriate training and credentials. Depending on the student's condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and licensed mental health professional. Any professional completing this form must have first-hand knowledge of the student's condition, experience in working with college students with psychiatric/psychological conditions and familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnosis of psychiatric/psychological disabilities documented by family members is unacceptable. For additional information regarding documentation guidelines, refer to the Educational Testing Services (ETS) guidelines.

Student: Complete this section

Student Name: ____________________________________ DOB: ____________________

Student ID: _______________________________

NeSCC-3 13-012 Rev 08/2019

Certifying Professional: Complete this section and all subsequent sections

Provider Name (printed): ____

Signature: ____

(Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document)

License Type: ____

License Number: ____________________ State: _______ Exp. Date: ____________________

Mailing Address: ____

City/State/Zip: ____

Phone: ______________________________ Fax: ______________________________

E-mail: ____

Diagnostic and Statistical Manual Diagnosis (DSM)

Axis I: ______________________________Code: ______________________________

Axis II: ______________________________ Code: ______________________________

Axis III: ______________________________ Code: ______________________________

Axis IV: ______________________________ Code: ______________________________

Axis V: ______________________________ Code: ______________________________

Primary diagnosis/diagnoses and date of onset:

____

____

Last appointment *(check one)*:☐ Less than 1 month ☐ Less than 1 year ☐ Greater than 1 year

Appointment frequency *(check one)*: ☐ Weekly ☐ Monthly ☐ Annually ☐ As Needed

Expected duration of primary condition *(check one)*: ☐ Permanent ☐ Temporary

How long do you anticipate that the student's academic achievement will be impacted by the primary condition?

☐ Greater than 6 months ☐ Greater than 1 year ☐ Less than 1 year

Student's prognosis?

____

____

____

____

Diagnostic Tools

In addition to DSM criteria, how did you arrive at your diagnosis/diagnoses?
(*Check any relevant items below)*

☐ Interviews with student

☐ Interviews with other person

☐ Behavioral observations

☐ Developmental history

☐ Neuro-psychological testing

☐ Psycho-educational testing

☐ Self-rated or interviewer rated scale

☐ Other: ______________________

Medication and Prescribed Aids

What medication and prescribed aids are currently being used in the treatment of the diagnosis/diagnoses above?

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Describe any medication side effects that may adversely affect the student's academic performance.

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Describe any other relevant aspects of this condition that may impact educational or interpersonal behavior and achievement.

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From your medical perspective describe possible accommodations that could facilitate the student's academic performance.

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Functional Limitations

Please indicate the current functional limitation(s) of the patient regarding the major life activities listed below. (*Check all that apply)*

Functional Limitation	Comments	Degree of Limitation
☐ Concentration		☐ Mild ☐ Moderate ☐ Severe
☐ Memory		☐ Mild ☐ Moderate ☐ Severe
☐ Information Processing		☐ Mild ☐ Moderate ☐ Severe
☐ Managing External Distractions		☐ Mild ☐ Moderate ☐ Severe
☐ Organization		☐ Mild ☐ Moderate ☐ Severe
☐ Stress Management		☐ Mild ☐ Moderate ☐ Severe
☐ Social Interaction		☐ Mild ☐ Moderate ☐ Severe
☐ Activities of Daily Living		☐ Mild ☐ Moderate ☐ Severe
☐ Other *(Please Specify)* ______________________		☐ Mild ☐ Moderate ☐ Severe