ILLINOIS COMMUNITY COLLEGE OFFICE OF DISABILITIES SERVICES

Verification Form for Mental Health Conditions

Illinois Valley Community College (IVCC) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Amendments Act of 2008 (PL 110-325) to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the IVCC’s programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. It is important to note that a mental disorder in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

The Office of Disabilities Services (ODS) strives to insure that qualified students with psychiatric disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The Disabilities Services Office can not modify requirements that are essential to the program of instruction.

This form is designed to allow us to achieve these goals. Students who wish to receive academic accommodations due to a mental health condition need to have this form filled out by a psychiatrist, licensed psychologist, certified social worker (CSW or ACSW) or licensed professional counselor. The professional completing this from must have first hand knowledge of the student's condition and must be an impartial professional who is not related to the student.

This form must be completed annually to receive accommodations. **No accommodations will be provided until this form is completed in full and submitted to the IVCC Office of Disabilities Services for review.**

**Student Information (This section to be completed by the student.)**

Last Name: ____________________________________ First: ___________ Middle Initial: _____

Student ID #: ___________ Date of Birth: _______ Phone: ____________________ (C) (H)___

Address: ____________________________________________________________________________

City: ___________________ State: ____ Zip Code: _______ E-Mail: __________________________

The following sections should be completed by the Certified Licensed Professional.

**Multi-Axial DSM IV Date of Diagnosis:**

Axis I: ___________________________ Axis II: ___________________________ Axis III: ___________________________

Axis IV: ___________________________ Axis V: ___________________________

Check all that apply for basis on which diagnosis was made:

___ Nuero-psychological testing  __ Date of Testing______  ___ Psycho-educational testing  __ Date of testing_______

___ Structured interviews  __ Unstructured interviews  __ Standardized rating scales  __ Unstandardized rating scales

___ Medical history  __ Developmental History  __ Interviews/w other persons  __ Other (please specify)

If psychological tests were used please include all scores used to support the diagnosis:
If the diagnosis includes a phobic response to exams, does the problem pose a substantial limitation to the student for demonstrating their knowledge of course material on an exam without accommodations?

______yes ______no Explanation:

**Current medications including dosage and side effects:**

**Long term medication plan:**

Current compliance with medication plan:

Prognosis for medication plan (Include likelihood of improvement or deterioration/w approximate time frame.):

**Planned therapeutic interventions:**

Prognosis for therapeutic interventions (Include likelihood for improvement/deterioration/w estimated time frame.):

Current compliance with therapeutic interventions:

Does this person currently pose a threat to him/herself or others? If so please specify in what ways.

History of hospitalization:

1. **Implications for Educational Success**

List any learning abilities specific to post secondary environment that are impaired by the psychiatric disability (e.g. difficulty with concentration, slow processing speed etc.):

2. **Suggested accommodations**

Final determination of appropriate accommodations IS determined by the IVCC Office of Disabilities Services in accordance with the mandates of the Rehabilitation Act of 1973 and The Americans with Disabilities Amendments Act of 2008 (PL 110-325) as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.

Please check suggested accommodation. Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed.

a. _____Extension of time to complete exams Why?

b. _____Quiet room in which to take exams Why?

c. _____Test read orally to student Why?
d. Other (please specify)  Why?

___ Yes  ___ No  Does the current medication/therapies provide the needed stability for the student to meet Post-secondary classroom/course expectations on a daily basis?

3. Please check the level of limitation for the following activities:

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<th>Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<td>Memory</td>
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<td>Social Interactions</td>
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<td>Managing internal distractions</td>
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<td>Timely submission of assignments</td>
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<td>Attending class regularly</td>
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<td>Being on time for class</td>
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<td>Making/keeping appointments</td>
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<td>Stress management</td>
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<td>Organization</td>
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To be completed and signed only by certified licensed professional:

Name: _____________________________

Credentials: _____________________________

Address: _____________________________

City: _____________________________ State: _______ Zip Code: ___________

State of Licensure: _____________________________ License/Certification number: ___________

Date of initial contact with student: ___________ Date of last contact with student: ___________

Signature of Certified Licensed Professional _____________________________ Date ___________

If you have any questions regarding the nature of the information needed for students with psychiatric impairments, please call the IVCC Office of Disabilities Services:

Tina Hardy on Monday 8:30 to 3:00 Central Time, Wednesday 8:30 to 3:00 Central Time, Friday (8/15 to 6/15) 8:30 to 1:00 Central Time at 815-224-0284 or email tina_hardy@ivcc.edu (Note: underscore after tina)

OR

Judy Mika on Tuesday 9:30 to 5:00 Central Time, Wednesday 8:30 to 5:00 Central Time, and Thursday 8:30 to 3:00 Central Time at 815-224-0350 or email judy_mika@ivcc.edu (Note: underscore after judy)

This form should be returned to: Illinois Valley Community College, Office of Disabilities Services
ATTN: Tina Hardy/Judy Mika
815 N. Orlando Smith Avenue
Oglesby, Illinois 61348-9692

OR fax to 815-224-0572 ATTN: Tina Hardy/Judy Mika

ODS 06/03/2009