



IVCC Center for Accessibility & Neurodiversity

Verification Form for Mental Health Conditions

The Center for Accessibility & Neurodiversity (CAN) strives to ensure that qualified students with psychiatric disabilities are accommodated and, if possible, that these accommodations do not jeopardize successful therapeutic interventions. CAN cannot modify requirements that are essential to the program of instruction.

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 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 diagnosis 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.

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 form must have firsthand knowledge of the student's condition and must be an impartial professional who is not related to the student.**

IMPORTANT: Filling this form out in a *timely* and *thorough* manner is vital to providing reasonable accommodations for students. If you have any questions regarding the nature of the information needed for students, please call the IVCC Center for Accessibility & Neurodiversity Coordinator, Tina Hardy, at 815-224-0284 or email her at tina_hardy@ivcc.edu.

Student Information – This section to be completed by the student:

First Name: _____ MI: _____ Last Name: _____

Student ID: _____ DoB: _____ Ph #: _____ Cell/Home

Address: _____

City: _____ ST: _____ Zip: _____ Email: _____

The following sections should be completed by the Certified Licensed Professional

Diagnosis and Date of Diagnosis – Please list all relevant diagnoses in order of impact on academic performance from greatest to least:

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

- ☐ Neuro-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:

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 with approximate timeframe):

Planned Therapeutic Interventions:

Prognosis for therapeutic interventions (include likelihood for improvement/deterioration with estimated timeframe):

Current compliance with therapeutic interventions:

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 Center for Accessibility & Neurodiversity in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities 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 your *suggested* accommodations below. 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?

Does the current medication/therapies provide the needed stability for the student to meet post-secondary classroom/course expectations on a daily basis? ☐ YES ☐ NO

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

<u>Activity</u>	<u>No Impact</u>	<u>Moderate Impact</u>	<u>Substantial Impact</u>	<u>Uncertain</u>
Concentrating				
Memory				
Sleeping				
Eating				
Self-care				
Social interactions				
Managing internal distractions				
Managing external distractions				
Timely submission of assignments				
Attending class regularly				
Being on time for class				
Making/keeping appointments				
Stress management				
Organization				

This section to be completed and signed only by the certified licensed professional:

Name: _____ Credentials: _____

Address: _____
City ST Zip

State of Licensure: _____ License/Certification number: _____

Date of **initial** contact with student: _____

Date of **last** contact with student: _____

Signature of Certified Licensed Professional

Date

This form should be returned to: IVCC Center for Accessibility & Neurodiversity

ATTN: Tina Hardy

815 N. Orlando Smith Road

Oglesby, IL 61348-9692

OR faxed to 815-224-0295 ATTN: Tina Hardy

CAN 11/12/25