

CAPE COD COMMUNITY COLLEGE
O'NEILL CENTER FOR STUDENT ACCESS AND SUPPORT
2240 Iyannough Rd. West Barnstable, MA 02668-1599
(508) 774-4533 (508) 375-4110 (fax)

VERIFICATION OF MENTAL HEALTH DISORDER

OR

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD/ADD)

DATE: _____

TO: _____
(Name of Appropriate Practitioner)

FROM:

___ Douglas Terry
Coordinator, O'Neill Center
Student Access and Support
dterry@capecod.edu
774-330-4337

___ Jaclyn Kotowski
Learning Disabilities Specialist
jkotowski@capecod.edu
774-330- 4317

_____ is a student at Cape Cod Community College who is requesting academic accommodations/services through our Office. To determine this student's eligibility for academic accommodations under the Americans with Disabilities Act, and to ensure the provision of such services, the college requires documentation of the disability. Your assistance in furnishing pertinent diagnoses information that would enable us to accurately assess this student's specific accommodations would be greatly appreciated.

NOTE: See reverse side of this form for questionnaire to be completed by an appropriate licensed practitioner.

Student authorization to release information

I hereby authorized the above-named practitioner to release information regarding my disability to the O'Neill Center at Cape Cod Community College. I understand that the information will be used for documentation of my disability and to ensure the provision of reasonable and appropriate services. Furthermore, I understand all information provided will be held in strict confidence as specified in the rules and regulations of Cape Cod Community College.

Student Signature: _____

Date: _____

Patient's name: _____

Information to Document Mental Health Disorder or ADHD
To Be Completed by Psychiatrist/ Clinical Psychologist/ Neuropsychologist/ Psychiatric Nurse
Practitioner/License Certified Social Worker/License Mental Health Counselor
(A comprehensive Psychiatric report may be attached in lieu of completing this form)

1. **DSM-V/DSM-IV Classification:** _____

2. DSM-V/DSM-IV Criteria (symptoms) related to diagnostic category.
(Describe the symptoms, severity and longevity of the condition related to and that substantiate the diagnostic category.)

3. Date of onset, last date patient seen, type of evaluation conducted and treatment plan. If no treatment is being provided, please explain why the condition is severe enough to be considered a disability.

4. List medications and any side effects that maybe important in developing an accommodation plan.

5. Describe the substantial limitations to major life activities posed by the disability and describe the extent to which these limitations would impact the academic context.

6. You may offer suggestions for appropriate and reasonable accommodations at the post- secondary educational level.

Signature: _____

Date: _____

Print Name and License Title: _____

Address: _____

_____ Phone: _____

Email: _____