SAGINAW VALLEY STATE UNIVERSITY

Psychiatric Condition Accommodations Form

Please TYPE or PRINT to complete this form.

The student, whose name and signature are below, has requested academic accommodations and resources based on the diagnosis of a psychiatric or medical condition. The student is requesting that the following information be provided by a licensed psychiatric medical professional. Please complete and return this form, and/or send copies of diagnostic evaluations and progress reports (containing the requested information), to the address below. Please consider this signed form as authorization to release this information to the Offie of Accessibility Resources & Accommodations at Saginaw Valley State University.

Student Name: _____ Student Birth Date: _____

Student ID#:_____ Student Signature: _____

DIAGNOSIS INFORMATION - THIS FORM SHOULD ONLY BE COMPLETED BY THE DIAGNOSING CLINICIAN

Please note: The information provided is considered in determining appropriate academic accommodations and resources. Please attached the testing results report and any included documentation with this form.

Diagnosis:_____ DSM Diagnosis Code:_____

Date of Diagnosis:_____ Date of last contact:_____ Date of initial contact:_____

Assessment instruments and results:_____

_____

Describe the functional abilities/limitations of condition:_____

_____

List of medication(s)/assistance (Dosages, side effects, treatment plan):_____

_____

_____

_____

_____

_____

PROFESSIONAL CREDENTIALS

Name/Title:_____

License/Certification Number & State of Licensure: _____

Address: _____

Phone: _____ Fax: _____ Date:_____

Signature of certifying professional:_____

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