**Disability Support Services**
Alison Hall, Suite 130
240 Academy Street
Newark, DE 19716
Phone: 302-831-4643
Fax: 302-831-3261
TDD: 302-831-4563
Email: dssoffice@udel.edu

# Process for Determining Accommodations for a Psychological Disability

In order to provide accommodations the Office of Disability Support Services (DSS) requires specific information from both the student and a **qualified licensed professional** (such as psychologist, psychiatrist, qualified medical specialist or licensed clinical social worker) who does not have a personal relationship with the student. Accommodations are determined on a case-by-case basis in accordance with the Americans with Disabilities Act, as amended in 2008.

After the student has submitted the required documentation and completed the application form on SAM (found on the first page of our website), the student must call our office to make an appointment to meet with an Accommodation Coordinator to determine accommodation eligibility.

## Documentation from a qualified licensed specialist.

Completion of the Certification of a Psychological Disability form

***or***

A signed and dated letter that includes:

- Diagnosis using DSM criteria
- Date of diagnosis
- Symptoms experienced
- Describe the Major Life Activity (i.e. walking, breathing, seeing, hearing, learning, socializing) impacted. Please list activity, level of impairment, and impact in a university setting.
- Describe treatment
- Medication: dosage and side effects
- Expected duration of the condition
- Last date of treatment
- Recommended Accommodations

## Interview with student

- Discuss the impact of this condition on academic functioning both past and present
- Discuss accommodations

Documentation can be emailed, faxed, or uploaded into SAM.

The Office of Disability Support Services (DSS) will maintain the confidentiality of evaluations to the extent required by state and federal laws.

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## Certification of Psychological Disability

In order to provide accommodations the Office of Disability Support Services must receive specific information from licensed qualified professional who does not have a personal relationship with the student.

Student's Name (print)

1) Diagnosis
   DSM-5 Date
   Expected duration of the condition
   Temporary Permanent Stable Progressive
   DSM-5 Date
   Expected duration of the condition
   Temporary Permanent Stable Progressive
   DSM-5 Date
   Expected duration of the condition
   Temporary Permanent Stable Progressive
2) Symptoms experienced

3) Describe the Major Life Activity impacted. (i.e. walking, breathing, seeing, hearing, learning, socializing) Please list activity, level of impairment, and impact in an university setting.

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4) Medications and treatment: effects and possible side-effects

5) Accommodations recommended in a higher education setting

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***Must be completed by qualified licensed professional***

Date

Printed Name and Title of medical doctor or qualified professional

Signature of medical doctor or qualified professional

License Number

Address

Phone Fax Email