Psychological Disability Documentation
Instructions and Documentation Submission Form

Student Instructions and Information:

1. Students must submit medical documentation of a Psychological Disability from a qualified provider (medical doctor or psychiatrist) to the Access & Accommodations Center (AACE). You may do so by having your qualified provider complete this Form or by submitting a letter from a qualified provider that includes all of the information requested in this form. Letters from qualified providers must be on letterhead from the provider’s practice and must include the provider’s signature and credentials.

2. Documentation of a Psychological Disability must be current (3 years old or less). Less recent documentation may be submitted for review but may not be accepted if it fails to adequately indicate current functioning.

3. Students should submit the required medical documentation prior to the initial meeting with AACE since appropriate accommodations are discussed at that time.

4. How often medical documentation must be updated will be determined by AACE based on the student’s individual situation.

5. Documentation may be submitted through the AIM portal at https://access.gsu.edu/

To be Completed by Student:

Name (Last, First, Middle): ________________________________________________________________
Date of Birth: __________________ GSU ID: ________________________________________________
Cell Phone: ___________________ Alternate Phone: __________________
Home Address: _____________________________________________________________
_______________________________________________________________________________
Email Address: _________________________________________________________________
Status (Check One): _____Current Student _____ Transfer Student _____ Prospective Student
To be Completed by Provider:

To establish eligibility for accommodations under the ADA, students must submit current and comprehensive medical documentation from a qualified provider for any diagnosis of a disability. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

Primary Diagnosis: ________________________________________________________________

DSM-5 Code: ___________________________ Date of Diagnosis: __________________________

Secondary Diagnosis: ______________________________________________________________

DSM-5 Code: ___________________________ Date of Diagnosis: __________________________

Please provide the diagnostic criteria and methodology used to diagnose the condition.

______________________________________________________________________________

______________________________________________________________________________

Please check any of the following as appropriate to describe the patient’s symptoms and/or behavioral manifestations.

___ Feeling sad or down  ___ Alcohol or drug abuse  ___ Major changes in eating habits
___ Confused thinking or reduced ability to concentrate  ___ Sex drive changes
___ Excessive fears or worries  ___ Excessive anger, hostility or violence
___ Extreme feelings of guilt  ___ Suicidal thinking
___ Feelings of worthlessness or self-hate  ___ Agitation, restlessness, and irritability
___ Extreme mood changes of highs and lows  ___ Feelings of hopelessness and helplessness
___ Withdrawal from friends and activities  ___ Heart palpitations
___ Significant tiredness, low energy  ___ Chest pain
___ Problems sleeping or excessive sleeping  ___ Rapid heartbeat
___ Detachment from reality (delusions), paranoia or hallucinations  ___ Headaches
___ Inability to cope with daily problems or stress  ___ Sweating
___ Trouble understanding and relating to situations and to people
    ___ Other

___ Other

___ Other
Please describe the history and severity of the disorder.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Is it expected that the patient’s functioning and/or severity of the disorder will change over time?
_____Yes _____No

If yes, please explain the anticipated progression.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please check all of the following as appropriate to describe the patient’s functional limitations. This list of possible functional limitations is from the Center for Psychiatric Rehabilitation, 1997

_____Difficulty with medication side effects: side effects of psychiatric medications that affect academic performance include drowsiness, fatigue, dry mouth and thirst, blurred vision, hand tremors, slowed response time, and difficulty initiating interpersonal contact.

_____Screening out environmental stimuli: an inability to block out sounds, sights, or odors that interfere with focusing on tasks. Limited ability to tolerate noise and crowds.

_____Sustaining concentration: restlessness, shortened attention span, distraction, and difficulty understanding or remembering verbal directions.

_____Maintaining stamina: difficulty sustaining enough energy to spend a whole day of classes on campus; combating drowsiness due to medications.

_____Handling time pressures and multiple tasks: difficulty managing assignments, prioritizing tasks, and meeting deadlines. Inability to multi-task work.

_____Interacting with others: difficulty getting along, fitting in, contributing to group work, and reading social cues.

_____Fear of authority figures: difficulty approaching instructors and/or teaching/lab assistants.

_____Responding to negative feedback: difficulty understanding and correctly interpreting criticism or poor grades. May not be able to separate person from task (personalization or defensiveness due to low self-esteem).

_____Responding to change: difficulty coping with unexpected changes in coursework, such as changes in the assignments, due dates, or instructors. Limited ability to tolerate interruptions.

_____Severe test anxiety: such that the individual is rendered emotionally and physically unable to take the exam.

_____Other ____________________________________________________________________________________
Please provide any additional information/context as appropriate concerning the functional limitations.

Please provide any recommendations to address the indicated functional limitations.

Please attach any psychological and/or educational reports that support the diagnosis and complete the following information:

Provider Name: ________________________________________________________________

Title: _______________________________________________________________________

License #: ____________________________________________________________________

Practice Name and Address: _______________________________________________________ 

Phone: ___________________________ Fax: ________________________________

Email: ______________________________________________________________________ 

Provider Signature (Wet Signature Required): ______________________________________

Date of Signature: __________________________________________________________________