Columbia International University  
Academic Success Center  
Verification of Emotional/Psychological Disability

Student’s name: ________________________________________________________

CIU student ID #: ______________________________  Today’s date: ______________________________

Semester services are requested for: __________________________________________

My signature grants the release of the requested information to Columbia International University.

Student’s signature: ______________________________________________________

The above student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodation from the Academic Success Center due to an emotional or psychological disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

In order to consider the request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, Columbia International University policy requires that a qualified professional provide current and comprehensive verification of the disorder.

Disability documentation should be current and relevant but not necessarily recent. The professional conducting the assessment and rendering the diagnosis must be qualified to do so. A qualified professional includes a licensed psychologist, psychiatrist, or physician that follows DSM-V diagnostic procedures.

The documentation and information must be sufficient to support current functional limitations in a college academic and residential setting. The report should include a clearly stated diagnosis of impairment, severity and longevity of the condition, current medications and dosages, and instruments and procedures used for the evaluation. The report should also offer recommendations for necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations related to the academic or residential environment.

To facilitate the gathering of such critical information, please respond to the following questions, attach the diagnostic report(s), and return to:

Lisa M. Lanpher, M.Ed.  
Academic Success Center Director  
Columbia International University  
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P. O. Box 3122  
P.O. Box 3122  
Columbia, SC  29230-3122  

Phone: (803) 807-5611  
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e-mail: llanpher@ciu.edu  
Updated 070815
Columbia International University
Verification of Emotional/Psychological Disability
To be completed by a qualified professional

Please write legibly:

Student’s name: ___________________________ Today’s date: ___________________________

1. DSM-V Diagnosis (Clinical/Other disorders related to disability accommodations):
   Diagnostic Code    DSM-V Name
   ___________________ _____________________________________________________________
   ___________________ _____________________________________________________________
   Other Comments: ________________________________________________________________

2. Date of diagnosis: _____________________ Date of last assessment: _____________________
   Approximate date of onset: ___________________________

3. Condition severity (check one): _____Mild   _____Moderate   _____Severe
   Condition is considered (check one): _____ Temporary   _____ Permanent

4. Clinical tools that were used to assess the following (attach diagnostic report including scores and interpretations):
   Attention: ________________________________________________________________
   Aptitude: _________________________________________________________________
   Achievement: _____________________________________________________________
   Social-Emotional Functioning: _______________________________________________
   Other: ___________________________________________________________________

5. Symptoms that meet the criteria for DSM-V diagnosis: ____________________________
   __________________________________________________________________________
   __________________________________________________________________________

6. Current medications, dosage and frequency: ______________________________________
   __________________________________________________________________________
   __________________________________________________________________________

7. Possible impact and side effects of the medications identified above: ________________
   __________________________________________________________________________
8. In your professional opinion, how frequently are evaluations needed to maintain current functioning information for this client.

____________________________________________________________________________

9. Provide a summary of the student’s educational, medical, and family history that may relate to the diagnosis. Include specific information to demonstrate interference with educational achievement:

____________________________________________________________________________

____________________________________________________________________________

10. Student’s functional limitations in an educational setting: ______________________________

____________________________________________________________________________

11. Student’s functional limitations in a residential setting: ______________________________

____________________________________________________________________________

12. Your recommendations regarding necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations to equalize the student’s educational opportunities at Columbia International University (describe recommended aids):

____________________________________________________________________________

____________________________________________________________________________

13. Concerns you may have regarding the ability of this student to participate in higher education or the ability of the university to effectively accommodate the disability:

____________________________________________________________________________

____________________________________________________________________________

14. Attach and/or describe other information relevant to this student’s academic adjustment:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Professional’s Signature: _______________________________ Date: ____________________
Printed Name and Title: __________________________________________
Professional’s Area of Specialization: ______________________________
Daytime Phone Number: _______________________________ Fax: _____________________
Address: ____________________________________________________________

Please complete the entire form, sign, and attach a diagnostic report and any other supporting documentation.