New York Institute of Technology

VERIFICATION OF PSYCHIATRIC CONDITION

TO BE COMPLETED BY THE APPROPRIATE TREATING CLINICIAN (Documentation must be completed no more than 6 months of requesting accommodations)

Date: _____

I, the undersigned, certify that:

Name of Student: _____ Date of Birth: _____

Address: _____

Phone :(_____) _____

Has the following diagnosis/condition:

1. Diagnosis/Description of Psychiatric Condition: Please provide full DSM-V code.

   _____

   _____

   _____

2. Symptoms/Manifestations: (e.g., mood lability; difficulties with attention, memory, or expression).

   _____

   _____

   _____

3. This individual's condition substantially limits him or her in a major life activity? ☐Yes ☐No

   If yes, what activities are significantly limited? _____

   _____

   _____

4. Date the diagnosis was formally established: _____
5. Verification of Psychiatric Condition-2: _____
6. Current Treatment(s)/Therapy and Prescribed Medications and Dosage: _____

   _____

   _____

7. The condition is:

☐Pemanent/Chronic ☐Long term: 3-12 months

☐Short term: Temporary: less than 3 months

8. Please list any academic or other disability accommodations you recommend: _____

_____

_____

_____

9. Please use the space below (and additional sheets as needed) to provide any other information that will be helpful to University staff in considering the accommodations that you are recommending. You may choose to address these questions:

a. What is the likely impact on academic performance if the request is not met? _____

_____

_____

b. What is the likely impact on social development if the request is not met? _____

_____

_____

c. Is the request an integral component of a treatment plan for the condition in question? _____

_____

_____

Certifying Professional:

Signature: _____ Date: _____

Name (Please Print): _____

Title: _____

Name of Agency: _____

Street Address: _____

City/State/Zip: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

All documentation submitted for consideration to OAS is confidential. When submitting documentation, please include a copy of any available releases allowing communication between the OAS and the diagnostician.

Documentation should be sent to:

Office of Accessibility Services
NYIT P.O. Box 8000
Old Westbury, NY 11568
Fax: (516) 686 - 7891
Phone: (516) 686 – 7976

All recommendations are considered. Decisions are made based on the nature of the disability, reasonableness of the request, and academic integrity.