The Office of Disability Services (ODS) provides academic accommodations and services to students with Psychiatric Disabilities. Students seeking accommodations must provide appropriate documentation of their disability so that ODS can determine the student’s eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. The documentation must describe a disarming condition, which is defined by the presence of significant limitations in one or more major life activities.

To verify the disability and its severity, ODS requires the following current documentation from a physician or other approved specialist with experience and expertise in the area related to the student’s disability.

Documentation should include:

- **A current** clear statement of disability including diagnosis and DSM-5 or ICD Diagnosis (text and code) and information concerning co-morbidity
- Documentation must be current, not more than one year old. In some cases documentation may need to be provided every six months, depending on the fluid or static state of their disability.
- **Current Functional Limitations**: Information concerning the impact of the disability on major life activities as well as the functional limitations and how they currently interfere in the educational setting. Again, factors to consider include the severity, duration, and pervasiveness of symptoms.
- A narrative clinical summary of assessment procedures that were used to make the diagnosis, evaluation results, and list any recommended accommodations. Summary must include psychiatric history.
- Suggested accommodations to address each limitation as well as history of accommodations used.
- The diagnostic report must include the name, and title, and license number of the evaluator.
- The evaluation and documentation must have been conducted by a licensed psychiatrist, neuropsychologist or other qualified and licensed mental health or medical professional.
- A complete Disability Verification Form (please do not write “see attached”)

**Please note**: all appropriate documentation must be received prior to formal review process commencing. Also please be aware that provision of accommodations in High School, other non BU academic institution or on any standardized test does not guarantee that the same or any accommodations will be awarded at Boston University.

**All documentation is considered confidential and can be mailed or faxed to:**
Office of Disability Services
19 Deerfield St, second floor
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646
access@bu.edu
www.bu.edu/disability
Office of Disability Services for Students  
Disability Verification Form – Psychiatric Disabilities

This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of Psychiatric Disabilities at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

Documentation must be current, not more than one year old. In some cases documentation may need to be provided every six months, depending on the fluid or static state of their disability.
Please include a copy (including test scores) of any relevant adult normed psychoeducational or neuropsychological reports. All information will be kept confidential. Please feel free to contact ODS at (617)353-3658 with any questions.

PLEASE NOTE: If you do not have current testing please refer to the to our documentation guidelines at: http://www.bu.edu/disability.

Student name: ____________________________ Date: ____________________________
Name: (please print) ____________________________ BU ID: ____________________________

For the current treating healthcare provider to complete:

1. Please list all DSM-5 or ICD Diagnoses (text and code):
   Diagnoses ____________________________
   a. Date diagnosed: ____________________________
   b. Date of your last clinical contact with student: ____________________________
   c. Current severity: ____________________________

2. Evaluation
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      O Structured or unstructured interviews with student.
      O Interviews with other persons (i.e. parent, teacher, therapist).
      O Behavioral observations.
      O Neuropsychological testing. Attach documentation.
      O Psychoeducational testing. Attach documentation.
      O Other (Please specify). ____________________________
   b. Date of last evaluation ____________________________

3. Functional Limitations  Y ☐  N ☐ If yes, please describe: ____________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
a. Please describe in detail any functional limitations that fall into the significant range.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

b. Please list current medications and treatment history.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

c. Special considerations, e.g. medication side effects:
_____________________________________________________________________________________
_____________________________________________________________________________________

4. Coexisting Conditions
   Please provide details about any coexisting psychiatric conditions.
   Please include all relevant reports.
_____________________________________________________________________________________
_____________________________________________________________________________________

5. Past Accommodations
   Please mark whether student has utilized accommodations in the past. Y □ N □
   Please describe:__________________________________________________________
   ____________________________________________________________

6. Suggested Accommodations
   Please list the specific academic accommodations you suggest based on your assessment of the
   students clinical and academic history and diagnosis. ________________________________________
   ____________________________________________________________
   ____________________________________________________________

7. (Optional) Please provide any additional information you feel will be useful in determining the nature
   and severity of the student’s disability, and any additional recommendations that may assist in
determining appropriate accommodations and interventions:
_____________________________________________________________________________________
_____________________________________________________________________________________

Thank you for your help in providing this information so that we may begin services as soon as possible.
Please complete the provider information below. This form should be signed and returned to ODS at the
address shown at the end of this document.

• PLEASE NOTE: To provide documentation of AD/HD, the evaluation must have been conducted
  or formally supervised by a licensed psychiatrist, neuropsychologist or other qualified and
  licensed mental health or medical professional.
Provider Information
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

If filling out online, in lieu of signature, please click here to certify that the above statement is true.  Y ☐  N ☐

Signature: ________________________________ Date: ________________________

Print Name and Title: ____________________________________________________

State of License: License Number: _________________________________________

Address: _______________________________________________________________

Street or P.O. Box City State Zip: __________________________________________

Phone: ________________________________ Fax: _____________________________

Please return this signed form to:
Office of Disability Services,
19 Deerfield St, second floor
Boston, MA  02215
Phone: 617-353-3658
Fax: 617-353-9646