

Academic Accommodations Documentation Form

Pitzer College
1050 North Mills Ave.
Claremont, CA 91711
Phone: 909-621-8241

A patient/client of yours has requested disability-related services from Pitzer College. Eligibility for such services is based on an individual providing sufficient information to conclude that the student has a disability/condition that substantially limits one or more major life activities. Documentation must be provided by a qualified professional, preferably a psychiatrist, licensed clinical psychologist, neurologist, clinical social worker or marriage and family therapist who is not a relative of the student. As this student's treating specialist, you are asked to provide the following information to allow Pitzer College to consider this student's service requests(s). You may also want to attach additional information that supports the diagnosis if relevant.

Student Name _____

1. Diagnosis(es): _____

Last contact with student: _____

2. Date of diagnosis: _____

3. Will you continue to see the student? No _____ Yes _____

4. What assessment instruments were used to make the diagnosis?

- | | |
|--|---|
| <input type="checkbox"/> Structured or unstructured interviews and pertinent history | <input type="checkbox"/> Standardized or unstandardized rating scales |
| <input type="checkbox"/> Behavioral observations | <input type="checkbox"/> Interview with other persons |
| <input type="checkbox"/> Psychiatric consultation | <input type="checkbox"/> Other (Please specify) |

5. What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

- | | |
|---|---|
| <input type="checkbox"/> Temporary – Date disability will end: _____ (Accommodations not necessary after this date.) | <input type="checkbox"/> 1 year |
| <input type="checkbox"/> 6 months | <input type="checkbox"/> More than 1 year |

6. Indicate the major symptoms of the disorder and level of severity currently experienced by the student.

| Symptom | Mild | Moderate | Severe |
|---------|------|----------|--------|
| | | | |
| | | | |
| | | | |

7. Please check which of the major life activities listed below are impacted. Please indicate the level of severity.

| Life Activity | No Impact | Impact | Substantial Impact | Don't Know |
|-------------------------------------|-----------|--------|--------------------|------------|
| Concentrating | | | | |
| Memory | | | | |
| Sleeping | | | | |
| Eating | | | | |
| Social Interactions | | | | |
| Self-care | | | | |
| Managing Internal Distractions | | | | |
| Managing External Distractions | | | | |
| Timely Submission of Assignments | | | | |
| Attending Class Regularly & on Time | | | | |
| Making & Keeping Appointments | | | | |
| Stress Management | | | | |
| Organization | | | | |
| Test Taking | | | | |
| Other | | | | |

8. What are your specific recommendations for this student regarding academic accommodations in a college environment? Examples of accommodations include extended time on exams, testing in a distraction-reduced setting, note taker, audio format of text, ect:

Clinician Name *in print* License

Professional Degree

Address

e-mail phone#

Signature _____ **Date** _____