TEXAS A&M UNIVERSITY
CORPUS CHRISTI

Disability Services
6300 Ocean Drive, Unit 5717
Corpus Christi, Texas 78412-5717
Office: 361-825-5816 · Fax: 361-825-2536

PSYCHOLOGICAL DISABILITY VERIFICATION FORM

SECTION I – To be completed by the student

Name _____ Student ID#_____

Address _____

Phone _____ Date of Birth _____

Psychologist/Psychiatrist/Physician: _____

Phone _____ FAX _____

Address _____

_____

I authorize the release of the information requested on this Disability Verification Form to the Disability Services Office at Texas A&M University-Corpus Christi.

_____ _____

Student Signature Date

SECTION II – To be completed by the Psychologist, Psychiatrist, Physician

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW TO ASSIST US IN DETERMINING AND PROVIDNG REASONABLE ACADEMIC ACCOMMODATIONS.

DSM IV:

Axis I: _____
Code

Axis II: _____
Code

Axis III: _____

Axis IV: _____

Axis V: _____/_____
Current GAF ***Highest GAF***

Continued on Reverse

Does this condition interfere with one or more of the following major life activities?

☐ **caring for self** ☐ **performing manual tasks** ☐ **walking** ☐ **standing** ☐ **lifting** ☐ **bending** ☐ **seeing**

☐ **hearing** ☐ **breathing** ☐ **speaking** ☐ **eating** ☐ **learning** ☐ **reading** ☐**concentrating** ☐ **thinking**

☐ **communicating** ☐ **working**

Describe the functional limitations and any other factors that may impact the student in an educational setting (e.g., easily distracted, poor concentration, difficulty focusing for extended periods of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations)**:**

_____

_____

_____

_____

_____

Certifying Licensed Psychiatrist, Clinical Psychologist, Physician

_____

Name Typed or Printed Signature

Address_____

City_____ State_____ Zip_____

Date_____

License # _____