Student Accessibility
College Center, Room C-019
800 Main Street, Pewaukee, WI 53072
Voice/Relay: 262.691.5318 | Fax: 262.691.5089
SAO@wctc.edu

Psychological Disability Certification

The student named below has applied for services from the Student Accessibility Office at WCTC. In order to provide reasonable and appropriate services for students with psychological disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist the Student Accessibility staff in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

Please print legibly

1. Student's name _____ Date _____

2. Date of your last contact with student _____ Student's DOB _____

3. What is the diagnosis for this student?_____

_____

4. Please indicate medications that have been prescribed for this student.

   Medication(s), dosage, and date first prescribed _____

5. What methods or testing instruments did you use to arrive at your diagnosis? Please check all relevant items adding brief notes that you think might be helpful to us as we determine which accommodation services are appropriate for the student.

   - ☐ Structured or unstructured clinical interviews with the individual
   - ☐ Interviews with other individuals
   - ☐ Developmental history
   - ☐ Medical history
   - ☐ Psychological testing – date(s) of testing? _____
   - ☐ Standardized or non-standardized rating scales
   - ☐ Other (please specify): _____

6. Please describe the functional limitations this student encounters when using medication.

_____

_____

_____

(continued)

WAUKESHA COUNTY TECHNICAL COLLEGE

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(continued)

7. Please assess degree of functional limitations due to psychological disability demonstrated by your patient:

	1 = Negligible	*2 = Moderate*	*3 = Substantial*	*4 = Severe*	*UN = Unknown*
a. Time Management	1	2	3	4	UN
b. Organizational Skills (physical and/or cognitive)	1	2	3	4	UN
c. Task Persistence	1	2	3	4	UN
d. Memory Skills	1	2	3	4	UN
e. Reading (fluency, comprehension)	1	2	3	4	UN
f. Quantitative Skills	1	2	3	4	UN
g. Written Expression	1	2	3	4	UN
h. Employment/Work Skills	1	2	3	4	UN
i. Self Esteem/Social Skills	1	2	3	4	UN
j. Other:	1	2	3	4	UN

8. Please describe an appropriate intervention plan and indicate how the plan will be managed:

Treatment/Intervention	*Provide*	*Needs Referral*
• Pharmacology (treatment and medication)	☐	☐
• Compensatory strategies (please specify) _____	☐	☐
• Academic study skills (please specify) _____	☐	☐
• Brief psychotherapy	☐	☐
• Long-term psychotherapy	☐	☐
• Other (please specify) _____	☐	☐

9. Please indicate which accommodations, if any, may be beneficial to this student.

- ☐ Low distraction test environment
- ☐ Extended test time
- ☐ Note taking support
- ☐ Reduced credit load
- ☐ Other (please specify): _____

10. Is there anything else you would like us to know about this student?

Signature of professional _____ Date _____

Medical professional's name (printed) and title _____

License number _____

Address _____ City _____

State _____ Zip _____

Telephone number _____ Fax number _____

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