

# CAAS

Center for Access and Accommodative Services

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Center for Access and Accommodative Services  
Triton College  
2000 Fifth Ave., River Grove, IL 60171, Room A-105  
Phone: (708) 456-0300, Ext. 3917, Fax: (708) 456-0991  
caas@triton.edu

## PSYCHIATRIC DISABILITY DOCUMENTATION

The student, whose name and signature appear below, has requested accommodative services based on the diagnosis of a psychiatric disability or condition. Students requesting services from the Triton College Center for Access and Accommodative Services are required, under Section 504 of the Federal Rehabilitation Act of 1973, to submit documentation to verify eligibility. This form must be completed by a psychiatrist, licensed psychologist or certified social worker (CSW or ACSW). **Please complete and return this form in a sealed envelope or by fax to the attention of C.A.A.S.**

*Please note: Accommodations will be provided only upon receipt of complete and adequate documentation.*

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Student Name

Signature

Birth Date

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Professional Credentials

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Professional Name

Title

Office Phone

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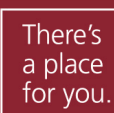
Office Address

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License/Certification Number & State of License

DSM/ICD CODE (S)

Diagnosis/Diagnostic code:



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DSM/ICD CODE (S)	DIAGNOSIS

**Is this person currently receiving regular counseling? How frequently?**

**Vocational, social, interpersonal impact.**

**Level of current functioning** (even with benefits of treatment, GAF score)

**Impairment of learning abilities**

(difficulty with concentration, memory, slow processing speed, etc.)

**Does this person pose a threat to themselves or others (explain)?**

**Current medications:**

MEDICATION	DIAGNOSIS	SIDE EFFECTS

**History of Hospitalization(s):**

**Recommendation for Accommodation and/or Support Services:**

Indicate which, if any, of the accommodations listed below would be appropriate:

- \_\_\_\_\_ Notetakers to supplement this student's notes
- \_\_\_\_\_ Extended time on exams
- \_\_\_\_\_ Distraction free testing environment
- \_\_\_\_\_ Test read aloud
- \_\_\_\_\_ Recording of lectures
- \_\_\_\_\_ Other (please specify): \_\_\_\_\_

I RECOMMEND THE FOLLOWING COURSE LOAD:					
	Minimal part time		Part time		Full time
	1 Class		2-3 Classes		4-6 Classes
	Approximately 3-5 credit hours		Approximately 6-9 credit hours		Approximately 12-15 credit hours

I certify that the above stated information is correct based on my professional judgment.

Signed \_\_\_\_\_

Date: \_\_\_\_\_



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