



SIMMONS COLLEGE
DISABILITY SERVICES
ACADEMIC SUPPORT CENTER, SUITE P304
300 The Fenway · Boston, Massachusetts 02115.5898
phone: 617.521.2473 fax: 617.521.3079

Student Name: _____
Social Security Number: _____
Simmons ID Number: _____

Simmons College requires the submission of documentation for students with psychiatric/psychological disabilities who request accommodations through the College. Students must submit a current diagnosis (within the last three years) by a licensed health professional (psychologist, psychiatrist, or a neurologist). The age of acceptable documentation is dependent upon the disabling condition, the current status of the student and the student's specific request for accommodations. Disabilities that are sporadic or progressive may require more frequent evaluations. Please have your health professional complete the following information:

(Add attachments as necessary)

■ Section One – Diagnosis Information

PRIMARY DIAGNOSIS (DSM IV CODE): _____

DATE OF ESTABLISHMENT: _____ DATE OF LAST EVALUATION: _____

HISTORY OF SUBSEQUENT PROGRESS AND TREATMENT (INCLUDING HOSPITALIZATIONS): _____

■ Section Two – Evaluation Procedures

DESCRIBE STUDENT'S PRESENT SYMPTOMS THAT MEET THE CRITERIA FOR THE DIAGNOSIS: _____

CURRENT GAF SCORE: _____ HIGHEST GAF SCORE IN PAST YEAR: _____

■ Section Three – Impact of Diagnosis and Recommendations

DESCRIBE THE LEVEL OF SEVERITY WITH WHICH THE DISABILITY AND ANY RELATED TREATMENT CURRENTLY IMPACTS THE STUDENT'S GENERAL FUNCTIONING:

DESCRIBE THE MANNER AND LEVEL OF SEVERITY WITH WHICH THE DISABILITY HAS A CURRENT AND SUBSTANTIAL IMPACT ON ACADEMIC FUNCTIONING (E.G. READING, MEMORIZING, WRITING, NOTE-TAKING, TEST-TAKING, ETC.): _____

DESCRIBE THE MANNER AND LEVEL OF SEVERITY WITH WHICH THE DISABILITY HAS A CURRENT AND SUBSTANTIAL IMPACT ON SOCIAL

FUNCTIONING: _____

WILL MEDICATION IMPACT THE STUDENT'S ABILITY TO MEET THE DEMANDS OF THE POST-SECONDARY ENVIRONMENT? _____ IF YES, DESCRIBE: _____
YES / NO

PLEASE PROVIDE A STATEMENT REGARDING THE USE OF COUNSELING OR THERAPY: _____

PLEASE PROVIDE A LIST OF APPROPRIATE ACCOMMODATIONS RECOMMENDED AND HOW THEY WILL ADDRESS THE STUDENT'S SPECIFIC NEEDS: _____

OTHER COMMENTS: _____

EVALUATOR: _____ NAME _____ TITLE _____ LICENSE NUMBER _____

ADDRESS: _____ STREET NAME AND NUMBER _____ SUITE _____

CITY _____ STATE _____ ZIP _____ PHONE NUMBER _____

SIGNATURE _____ DATE _____