

## **PSYCHIATRIC DOMAIN**

## PATIENT INFORMATION

(Please complete the relevant information and submit to your provider for completion)

Name:					Date:
Last	First		Middle Initial		
Psychiatric Condition Requiring Accommodation:					
Date of Birth:				People Soft Number:	
Status (check one):	Student	Staff	Faculty	Other (explain)	
Contact Phone Numbe	er:				
University E-Mail Address:			@pitt.edu		
Mailing Address:					
Please identify, for your treatment provider, the accommodations you are requesting from the University of Pittsburgh.					

## **PSYCHIATRIC DOMAIN**

PROVIDER: PLEASE COMPLETE

(Please type or print legibly)

The above named individual is requesting accommodations from the University of Pittsburgh. The University of Pittsburgh, for the purposes of establishing a disability and determining reasonable accommodations, requires current information about the condition. The information submitted will be examined in an individualized case-by-case inquiry, specifically looking at the impact of the condition on this individual and within the specific context of the requested accommodations.

Print Name:	Date:
License or Certification #:	
Mailing Address:	
Phone Number:	
Describe your professional credentials.	
2. Provide a diagnosis or diagnoses.	
<b>3.</b> Is this individual currently under your care for the above named condition?	Yes No

<b>4.</b> Establish the extent to which the psychiatric condition severity, frequency, and pervasiveness of this condition a that are affected. (This information will be used by qualif determine if the individual's requested accommodations are	t the <b>present time.</b> Identify major life activities ied personnel at the University of Pittsburgh to
5. Describe how the condition is currently being treated	or managed.
Signature:	Date:

Please return to:
Coordinator
Disability Resources and Services
221 Commons Building
mjd197@pitt.edu
Fax: 814-362-7518

Disability Verification Form: Psychiatric Domain