

### Mental Health Verification Form

Student Name and ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ BC Email: \_\_\_\_\_

The following information is to be completed by a qualified health professional and either returned directly to Accessibility Resources or the student. This information will be used to assist Broward College in determining appropriate accommodations.

Specific Diagnosis \_\_\_\_\_

Diagnostic Code \_\_\_\_\_

Circle One:            Mild            Moderate            Severe

Circle One:            Acute            Chronic

Date of Diagnosis \_\_\_\_\_

How long has the student been your patient? \_\_\_\_\_

Please attach any information that will assist Broward College with determining appropriate accommodations for this student, such as case notes, direct observations, psychological evaluations, or other test results.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name, Title, License Number

\_\_\_\_\_  
Address and Phone Number