

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