This information submitted to Disability Resources should reflect the most currently available information. **This Mental Health Disability Documentation Packet should:**

a) **Be completed by a qualified professional.**

b) **Be completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting will require additional follow up.

c) **Be supplemented with reports which may include psycho-educational or neuropsychological reports, if appropriate.** Please do not provide case notes or rating scales without a narrative that explains the results.

**COVID-19 Update:** While the university is minimizing in-person interactions and activities email, fax or postal mail are the preferred methods of delivery.

**Submit Information to:**

Disability Resources  
Texas A&M University  
471 Houston Street; 1224 TAMU  
College Station, TX 77843-1224  

FAX: (979) 458-1214  
EMAIL: disability@tamu.edu  
PHONE: (979) 845-1637 (voice/relay)

If you want to send in medical documentation in a secure format, you can use an encrypted file share service such as Filex ([https://filex.tamu.edu](https://filex.tamu.edu)) then send the link to the encrypted file and the decryption code to disability@tamu.edu.
Date: __________________

Student Name: ________________________________________________________    Birthdate: ____________

Last         First           M.I.

1. Date of first contact with this student:  _______________________________
   Date of last contact with this student:   _______________________________

2. Disability or disabilities:

   Disability: _______________________________________________________________
   Severity:  _____ Mild       _____ Moderate       _____ Severe

   Disability: _______________________________________________________________
   Severity:  _____ Mild       _____ Moderate       _____ Severe

   Disability: _______________________________________________________________
   Severity:  _____ Mild       _____ Moderate       _____ Severe

3. How did you arrive at your diagnosis? Please check all that apply.

   ____ Clinical Interview (Structured or Unstructured)
   ____ Psychoeducational Testing  (Dates of testing: _____________________________)
   ____ Neuropsychological Testing (Dates of testing: _____________________________)
   ____ Other – Please specify: ______________________________________________________

4. Please check all that apply to this student:

   Classroom:
   ____ has difficulty focusing as a result of their disability
   ____ is unable to simultaneously take notes and listen to what is being said
   ____ is unable to engage peers or work collaboratively
Exams:

_____ becomes overly anxious in timed situations (more than typical)
_____ experiences uncontrollable intrusive thoughts when under pressure and/or anxious
_____ engages in repetitive ritual(s) when under pressure and/or anxious
_____ subvocalizes thoughts or statements when under pressure and/or anxious

Attendance (If any are checked, see question 6):

_____ is sometimes unable to attend class or other activities due to her/his disability
_____ needs to sometimes leave class or other activities due to her/his disability
_____ needs to take short breaks from class or other prolonged tasks
_____ is not able to take a full course load of classes due to their disability

6. Give *rationale as to why this student cannot attend class or other activities*, if applicable.

7. Are there *other ways the student might be impacted* (socially, in housing, etc.)?

8. Discuss any *side effects related to treatment or medication* that may be relevant to identifying accommodations.
9. Please state any recommended academic accommodations with rationale.

10. Provide any additional information you feel is pertinent or may be of use in identifying appropriate accommodations.

Provider Information

Provider Name (Print): _______________________________________________________________
Provider Signature: __________________________________________________________________
License or Certification #: ___________________________________   State: ___________________
Address:  __________________________________________________________________________
Phone:   __________________________________ FAX: _____________________________________

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