BRUNSWICK
COMMUNITY COLLEGE

Release of Information

I, (student) _____, am requesting accommodations from Disability Services at Brunswick Community College on the basis of a psychological disability. By current definition, a psychological disability is coded on DSSM IV Axis I or II as moderate to severe, with a Global Assessment of Functioning (GAF) score of 60 or below, and interferes with major life functions. To qualify for accommodations, BCC will need verification now and each 12 months for which services are requested. I request that you complete all sections of this form, and submit findings and recommendations to Disability Services, Brunswick Community College, P.O. Box 30, Supply, NC 28462. Phone 910-755-7338 Fax 910-754-9609

_____ _____ _____

Date Signature of Student SS#

Julie Olsen
Assistant Dean of Students

1. DSM IV
   - AXIS I:____ _____
     - Code _____
   - AXIS II:____ _____
     - Code _____
   - AXIS III:____ _____
     - Code _____
   - AXIS IV:____ _____
     - Code _____

Date of Diagnosis:_____ Date of last visit:_____

Frequency of office visits:_____

What is the prognosis and what percent of recovery is expected?_____

_____

2. Is your patient ready to and capable of participating in this rigorous academic environment?

3. Does this condition interfere with one of the following major life activities?

____ Walking ____ Hearing _____Seeing
____ Working ____ Learning _____ Manual Tasks ____Concentration

4. What percentage of time (PIT) is your patient unable to perform the major life activity(ies) and what is the percentage of functioning (PIF) lost or seriously impaired (0 to 100%)?

Activity	PIT	PIF
_____	_____%	_____%
_____	_____%	_____%
_____	_____%	_____%

5. Please describe the functional limitation and/or behavioral manifestations (e.g. easily distracted, poor concentration, difficulty formulating and executing plan of action, difficulty coping with unexpected obstacles, panics in unfamiliar surroundings and situations, etc.) and recommendation you have prescribed:

Behavior	Recommendation
_____	_____
_____	_____
_____	_____
_____	_____

6. Please list any medications prescribed and the expected side effects, especially on cognition and learning activities:

Medication	Side Effects
_____	_____
_____	_____
_____	_____

7. Please disclose information you have concerning this student's intellectual capabilities. Please include a copy of any psychological/educational reports for our review.

_____
_____
_____
_____

Please circle one: Physician Psychiatrist Psychologist Other:_____

Providers Name_____ Title_____ License #_____
Address_____ Phone_____
Signature_____Date_____