

UNIVERSITY OF VIRGINIA  
LEARNING NEEDS AND EVALUATION CENTER

**VERIFICATION OF PSYCHIATRIC CONDITION**

TO BE COMPLETED BY THE APPROPRIATE TREATING CLINICIAN

Date \_\_\_\_\_

**I, the undersigned, certify that:**

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Has the following diagnosis/condition:**

1. Diagnosis/Description of Psychiatric Condition: **Please provide full DSM-IV code.**
2. Symptoms/Manifestations: (e.g., mood lability; difficulties with attention, memory, or expression):
3. This individual's condition:  
Substantially limits him or her in a major life activity  Yes  No  
If yes, what activities are significantly limited?



Signature

Date

Name *(please print)*

Title

Name of Agency

Phone Number

Street Address

City/State/Zip

All documentation submitted for consideration to LNEC is confidential. When submitting documentation, **please include a copy of any available releases** allowing communication between the LNEC and the clinician. Documentation should be sent to:

Learning Needs and Evaluation Center  
University of Virginia  
P.O. Box 800760  
Charlottesville, VA 22908

Fax: 434-243-5188

Phone: (434) 243-5180