Verification of Attention Deficit / Attention Deficit Hyperactivity Disorder

Qualified Professional's Statement

Office of Disability Services
P.O. Box 5005
Ashland, VA 23005
Phone: (804) 752-7343
Fax: (804) 752-3744
Email: dss@rmc.edu

Today's Date: ______________________________

Student Name: ____

The above named student is requesting accommodation(s) due to his/her ADD or ADHD under the Americans with Disabilities Act. In order to consider this request, as well as to ensure the provision of reasonable and appropriate accommodations, the College requires that current and comprehensive verification be provided by a qualified professional. The documentation and information provided must include information that diagnoses the ADD/ADHD, describes the ADD/ADHD in an educational setting, indicates the severity and longevity of the condition, and offers recommendations for necessary accommodation(s).

To facilitate the gathering of such critical information, please respond to the following questions, attach any appropriate diagnostic reports, and return to Randolph-Macon College, Office of Disability Services.

Please provide the following information:

DSM-V Diagnosis: ____

Level of Severity (Circle one): Mild Moderate Severe

Date of Diagnosis: ____

Date of your last contact with the student: ____

Describe the measures used to assess the diagnosis: ____

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Provide a summary of the student's educational or medical history that may relate to the ADD/ADHD disorder (*Must provide information regarding onset, longevity, and severity of symptoms, as well as specifics related to how it has interfered with educational achievement*). Notations of medications (if any) should be included:

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Describe the current functional limitations resulting from the disability or condition (*i.e., provide a clear sense of the severity or frequency of how the condition will impact the educational/residential setting*):

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Describe what, if any, accommodations would be reasonable and appropriate. These recommendations should logically relate and support the functional limitations in a classroom or residential setting.

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Professional's Signature: ____________________________________ **Date:** ______________________

Printed Name and Title: ____

License #: ____

Address: ____

Daytime Telephone Number: (______) __________-______________________________________

Return this verification form and any supplemental information to:

Randolph-Macon College
Higgins Academic Center
Office of Disability Services
P.O. Box 5005
Ashland, VA 23005

Phone: 804-752-7343
Fax: 804-752-3744
Email: dss@rmc.edu