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) 752-3152
Fax: (804) 752-3744
Email: dss@rmc.edu

Today's Date: _____

Student Name: _____

The above-named student is requesting accommodation(s) due to their 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 requests that current and comprehensive verification be provided by a qualified professional. The qualified professional should be a licensed or otherwise properly credentialed individual who has undergone appropriate and comprehensive training, has relevant experience, and has no personal relationship with the individual being evaluated. The individual making the diagnosis should have credentials directly related to the condition being reported (e.g., an orthopedic limitation should be documented by a physician, not a licensed psychologist).

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: _____

How long has the student been under your care for this condition?: _____

Describe the measures used to assess the diagnosis: _____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

Describe what, if any, accommodations are recommended to support this students' needs. These recommendations should logically relate and support the functional limitations in a classroom or residential setting.

_____

_____

_____

_____

_____

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: 804-752-3152
Fax: 804-752-3744
Email: dss@rmc.edu

Office of Disability Services (DS) will use the information on this form to determine the student's eligibility for disability services. DS is committed to ensuring that all information and communication pertaining to a student's disability be kept confidential as required by law.