Verification of Attention-Deficit Disorder (ADD)/ Attention-Deficit/Hyperactivity Disorder (ADHD)

RowanSOM Disability Services
Academic Center, Suite 210
1 Medical Center Drive
Stratford, NJ 08084
856-566-6980

1. Student Section

To determine eligibility for accommodations and support services, the Office of Academic Affairs / CTL requires specific information from both you and your provider. You must complete Student Section I, and your provider must complete Provider Section II. The entire verification form (all five pages) must be returned to the address listed above before services can be provided. Be sure to sign the release of information authorization below giving the Office permission to speak to your provider if there are questions related to your documentation.

A. STUDENT INFORMATION

STUDENT'S FULL NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

SOCIAL SECURITY OR BANNER ID NUMBER _____ GENDER: __ Male __ Female

HOME ADDRESS _____ STATE _____ ZIP _____

LOCAL ADDRESS _____ STATE _____ ZIP _____

HOME TELEPHONE _____ LOCAL TELEPHONE _____

E-MAIL ADDRESS _____

B. RELEASE OF INFORMATION AUTHORIZATION

I authorize the Office of Academic Affairs / CTL to receive information from the provider listed below. I also authorize my provider to discuss my condition(s) with the Office of Academic Affairs / CTL.

NAME OF PROVIDER _____ PROVIDER TELEPHONE _____

ADDRESS _____ STATE _____ ZIP _____

STUDENT SIGNATURE _____ DATE _____

2. Provider Section – ADD / ADHD Verification

Rowan University School of Osteopathic Medicine provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA, 1990) and section 504 of the Rehabilitation Act (1979).* To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing psychiatrist, psychologist or physician (the provider completing this form cannot be a relative of the student). Specific information concerning the student's condition and its impact on learning must be provided. Items 1-8 must be complete in full. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

A. PROVIDER QUESTIONNAIRE

Please respond to the following items regarding the student named above: (Please type or print)

1. What is the student's DSM IV diagnosis?

_____

a. How was this diagnosis arrived at? Please check and briefly discuss all relevant items below.

- ❑ Interview with student:

_____

- ❑ Interview with other person:

_____

- ❑ Behavioral observations:

_____

- ❑ Developmental history:

_____

- ❑ Medical history:

_____

- ❑ Educational history:

_____

- ❑ Psycho-educational testing:

_____

- ❑ Other (please specify)

_____

_____

* ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning.

b State the student's current symptoms that meet the criteria for this diagnosis.

c. State the age of onset of symptoms described by DSM IV.

d. What is the severity of the condition?

e. State the frequency of your appointments with this student and the date of your last contact.

2. Describe the differential diagnoses that were excluded. State your reasons for considering these diagnoses, and your reasons for ruling them out.

3. List and describe the measures/instruments used to support the student's attentional difficulties. (Attach diagnostic report including scores). It is necessary that psychometric testing be utilized to demonstrate attentional disorders. Assessments should include evidence of ADHD from several tests rather than just one test. Examples of measures are: continuous performance tests, The Stroop Test, Visual Search and Attention Test or other cancellation tasks, Paced Auditory Serial Attention Test, Attentional Capacity Test, Working Memory Index (WAIS), Sentence Repetition, Symbol Digits Modalities Test, etc.

4. Describe the symptoms related to the student's condition that causes significant impairment in a major life activity.

5. What symptoms cause impairment in two or more settings (e.g., work, home, school)?

6. List the student's current medication(s), dosages, frequency, and adverse side effects.

* ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning.

7. Please check off (and provide specific information if necessary) about the academic limitations and severity of symptoms this student's encounters:

ACTIVITY	NO LIMITATION	MODERATE LIMITATION	SUBSTANTIAL LIMITATION	DON'T KNOW
Attention to detail / accuracy of work				
Sustaining attention				
Listening comprehension				
Completing tasks independently				
Sustained mental effort				
Organization				
Distractibility				
Memory				
Restlessness				
Impulsiveness				
Time Management				
Mathematics				
Reading				
Writing				
Other (please specify)				

8 . Does the student have a disability* as a result of his/her condition? Yes_____ No_____
(Check "yes" if the student's condition requires accommodations.)

* ADA and sec. 504 define a disability as a physical or mental impairment that substantially limits one or more major life activities such as learning.

9. If yes, please state specific recommendations regarding accommodations for this student and a rationale as to why these accommodations are warranted based upon the student's functional limitations. Indicate why the accommodations you recommend are necessary.

10. If treatments (e.g., medications) are successful, why are the above accommodations necessary?

B. PROVIDER CONTACT INFORMATION

PROVIDER NAME AND TITLE

PROVIDER SIGNATURE | DATE

PROVIDER LICENSE NUMBER | ISSUING STATE

PROVIDER ADDRESS | STATE | ZIP CODE

PROVIDER TELEPHONE | PROVIDER FAX NUMBER