



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

Academic Success Center/Disability Resources

Savitz Hall
201 Mullica Hill Road
Glassboro, NJ 08028
856-256-4259

I. Student Section

To determine eligibility for accommodations and support services, the Office of Disability Resources 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 three 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 Disability Resources to receive information from the provider listed below. I also authorize my provider to discuss my condition(s) with the Office of Disability Resources.

NAME OF PROVIDER

PROVIDER TELEPHONE

ADDRESS

STATE

ZIP

STUDENT SIGNATURE

DATE

Rowan University Academic Success Center/Disability Resources VERIFICATION OF ADD/ADHD FORM	NAME OF STUDENT:
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II. Provider Section

Rowan University 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. State the student’s current symptoms that meet the criteria for this diagnosis.

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

c. What is the severity of the condition?

d. 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.

* 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.

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

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

6. Does the student have a disability* as a result of his/her condition? Yes No
(Check "yes" if the student's condition requires accommodations.)

7. 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.

8. 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

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