University of South Florida
Students with Disabilities Services

Verification Form for Students with Psychological Disabilities and Attention-Deficit/Hyperactivity Disorder

Students seeking support services from Students with Disabilities Services (SDS) on the basis of a previously diagnosed psychological disability or Attention-Deficit/Hyperactivity Disorder (AD/HD) are requested to submit documentation that verifies their eligibility under Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA) and the ADA Amendments Act. The documentation should describe a disabling condition, which is defined by the presence of substantial limitations in one or more major life activity. This form is intended to guide the documentation process. Please contact SDS at (813) 974-4309 with any questions. It is the student's responsibility to ensure that SDS receives this form or other appropriate documentation.

All documentation submitted to SDS is considered confidential.

Original copies of documentation will not be returned.

Student Information:

Name: _____

U Number: _____ Phone: _____

USF Email: _____ Date: _____

Provider Information:

I certify, by my signature below, that I am not related to the student. My signature also certifies that I conducted, or formally supervised and co-signed, the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

_____

State of License: _____ License Number: _____

Address: _____

Street or P.O. Box City State Zip: _____

Phone: _____ Fax:_____

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Information below is to be completed by the Provider.

1. ***If available,*** **please list all DSM-5 or ICD Diagnoses (text and code):**

_____

_____

   a. Date diagnosed: _____
   b. Date of your last clinical contact with student: _____

2. **Evaluation**
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      - ☐ Structured or unstructured interviews with student.
      - ☐ Interviews with other persons (i.e., parent, teacher, therapist).
      - ☐ Behavioral observations.
      - ☐ Neuropsychological testing. Attach documentation.
      - ☐ Psychoeducational testing. Attach documentation.
      - ☐ Other (Please specify).
        _____

   b. Current treatment being received by student:
      - ☐ Medication management:
        Current medications: _____
      - ☐ Outpatient therapy:
        Frequency: _____
      - ☐ Group therapy:
        Frequency: _____
      - ☐ Other (please describe):
        _____

   c. Approximate age of onset: _____

   d. Severity of symptoms
      ☐ Mild ☐ Moderate ☐ Severe

   e. Prognosis of disorder:
      ☐ Good ☐ Fair ☐ Poor

      Please explain:
      _____

      _____

3. Functional Limitations

a. Does this condition significantly **limit one or more of the following major life activities**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the current **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don’t Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

c. For the purpose of establishing reasonable accommodations, please provide any additional information you feel may be useful for us to know about the student’s disability, if applicable:

_____

_____

_____

_____

– Thank you –