REQUEST FOR DISABILITY VERIFICATION
OF A PERSVATIVE DEVELOPMENTAL DISORDER (Autism, Asperger’s)

To ensure the provision of reasonable and appropriate services for students, the Office of Disability Services requires students to provide current and comprehensive documentation of their disability and its impact on their education. Thank you for your assistance in this matter.

Student’s Name: _______________________________________________________________________

1. DSM-IV Diagnosis:  Axis I: _________________________
               Axis II: _________________________
               Axis III: ________________________
               Axis IV: ________________________
               Axis V: _________________________

2. Date of original diagnosis: ___________________________________________________________

3. Date of most recent evaluation: _______________________________________________________

4. Summary of symptoms and test results which support diagnosis.

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

5. Describe any treatment plan(s), including a description of the student’s responsibility.

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
6. Describe the student’s current functional limitations in an educational setting:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

7. Is this student currently on medication(s) that may affect their academic achievement? If so, provide relevant information about their medical history:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

8. Include any available results from aptitude and achievement testing. Describe below and attach a list of test instruments and results.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

9. Any suggested accommodations or recommendations?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student names above and that I am a licensed psychologist, neuro-psychologist, psychiatrist or other relevantly trained medical doctor.

Signature: ________________________________ Date: _____________________________

Print name and title: __________________________________________________________

State License__________________________ License Number: ________________________

Address: ____________________________________________________________________

Phone: ______________________________ Fax: ____________________________________