

To be completed by the student's evaluator
and then returned to the Office of Disability
Services

Office of Disability Services

111 Reid Centennial Hall

500 8th Avenue

Lewiston, ID 83501

Office: 208-792-2211

Fax: 208-792-2453

www.lcsc.edu/osl/ada.htm

**REQUEST FOR DISABILITY VERIFICATION OF
ATTENTION DEFICIT/HYPERACTIVITY DISORDER**

(ADHD) Combined Type, Predominately Inattentive Type, or
Predominately Hyperactive-Impulsive Type

To ensure the provision of reasonable and appropriate services for students with ADHD, the Office of Disability Services requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential.

Student's Name: _____

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

2. Date of original diagnosis (please include any evidence of early impairment, whether or not the student received treatment):

3. Date of most recent evaluation:

4. Summary of current symptoms, including ongoing problems with impulsivity, hyperactivity, or attention, plus, if available, information about organizational and time management.

5. Summary of test findings which support the diagnosis, including any results from aptitude and achievement testing. Please describe below and attach a list of test instruments, standard scores and percentiles. Subtest scores should be included.

6. How do the ADHD symptoms impact the student in an academic setting (functional limitations)?

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

8. (Optional) Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for accommodations that you believe will help equalize the student's ability to access the Lewis-Clark State College's educational program.

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

Signature: _____ Date: _____

Print Name and Title: _____

Area of Specialty: _____

State License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____