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 A PERVASIVE 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.

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

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

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

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

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9. Any suggested accommodations or recommendations?

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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: ______________________________________