THE UNIVERSITY of NORTH TEXAS HEALTH SCIENCE CENTER at FORT WORTH

Verification Form for Psychological Disabilities and ADHD

STUDENT INFORMATION

This box to be completed and signed by the student.

Student Name: _____ Student ID: _____

Phone Number: _____ UNTHSC Email: _____

Program: _____ Graduation Year if Applicable: _____

I understand that I am requesting my practitioner to provide complete and confidential information regarding my diagnosis. I also understand that completion of this form by a qualified practitioner does not guarantee accommodations.

Student Signature: _____ Date: _____

The student above is seeking accommodations through the Office of Disability Access. The Office of Disability Access provides appropriate and reasonable accommodations under the Americans with Disabilities Act of 1990, as amended. In order to determine eligibility, and to provide reasonable and appropriate accommodations, current and comprehensive information documenting the diagnosis and functional limitations of the disability is required. This form must be completed by a qualified professional who is not related to the student. Please provide the following information as completely as possible. Any missing information may require additional documentation. The completion of this form does not automatically qualify a student for accommodations and additional documentation may be required to determine appropriate and reasonable accommodations.

DIAGNOSTIC INFORMATION (TO BE COMPLETED BY A QUALIFIED PRACTITIONER)

Diagnosis

DSM/ICD Diagnosis Code and Name	Date of Diagnosis	Expected duration

Date of first contact: _____ Date of last clinical contact: _____

Additional Criteria for Diagnosis

In addition to DSM/ICD criteria, how did you arrive at your diagnosis? Please check all relevant items below and add brief notes that you think could be helpful in determining appropriate and reasonable accommodations.

Yes	Criteria	Additional Notes
☐	Structured or unstructured interviews with the student	
☐	Interviews with other persons	
☐	Behavioral observations	
☐	Developmental history	
☐	Educational history	
☐	Medical history	
☐	Neuro-psychological testing Date(s) of testing?	
☐	Psycho-educational testing Date(s) of testing?	
☐	Standardized or nonstandardized rating scales	
☐	Other (please specify)	

Please include a copy of any relevant neuro-psychological or psycho-educational reports, including test scores.

Functional Limitations

Note: Identification of functional limitations and severity should be noted without mitigating measures (i.e., medication, etc.). Include side effects of prescribed medications that affect functional limitations. When students respond well to treatment, symptoms may present no immediate limitations. Students may still qualify when the potential exists for a previously stable condition to worsen. Please complete this matrix to reflect those periods in which the condition **is not** well controlled.

Functional Limitations	No Impact	Moderate Impact	Substantial Impact	Unknown
Communication	☐	☐	☐	☐
Concentration	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Organization	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social interactions	☐	☐	☐	☐
Self-care	☐	☐	☐	☐
Timely submission of assignments	☐	☐	☐	☐
Making and keeping appointments	☐	☐	☐	☐
Attending class regularly and on time	☐	☐	☐	☐
Stress management	☐	☐	☐	☐
Other: Please specify below	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

For any above functional limitation marked “substantial”, please describe how the functional limitations would impact the student in the educational environment.

Current Treatment

Please complete for any current treatment the student is receiving.

Medication Management – current medications:

_____

Therapy – frequency and type:

_____

Other – please describe:

_____

Recommended Accommodations

(**Optional**) Please list any recommended accommodations that you feel would appropriately remove barriers for the student.

_____

Other

Please include any additional information you feel is needed to determine appropriate and reasonable accommodations.

_____

PROVIDER INFORMATION

By signing below I am certifying that I or my designee have completed this form truthfully and accurately.

Provider's Signature: _____ Date: _____

Provider's Name and Title (Please Print): _____

License or Certification number: _____ Phone: _____

Forms should be completed and returned to UNTHSC Office of Disability Access.

Office of Disability Access
Student Service Center, Suite 260
3500 Camp Bowie Blvd, Fort Worth, TX 76107
817-735-2134 FAX: 855-604-0915
www.unthsc.edu/ODA