



FERRIS STATE UNIVERSITY

Educational and Career Counseling Center and Disabilities Services

ADHD Disability Professional Documentation/Verification Form

This form is for ADD/ADHD only. ADD/ADHD Documentation Verification also requires the *Physicians Statement of Long Term Medical, Physical and/or Sensory Documentation/Verification Form*. Autism Spectrum/Pervasive Developmental Disorders require completion of the *Autism Spectrum/Pervasive Developmental Disorder Documentation/Verification Form*; Medical, Physical and Sensory conditions require the completion of the *Physician's Statement of Long Term Medical, Physical and/or Sensory Disability Documentation/Verification Form*; Psychiatric/Psychological conditions require the completion of the *Psychological/Psychiatric Verification Form*.

The student named below is requesting reasonable and appropriate accommodations for Attention Deficit Hyperactivity Disorder (ADHD). In order to provide these services, the student must provide recent documentation verifying the condition and describing its current functional impact. The report should provide information supporting a diagnosis consistent with the DSM-IV, in documenting ADHD in adults. Appropriate services will be based upon the specific information provided.

The diagnosis of a disorder such as ADD/ADHD does not, in itself, entitle an individual to accommodations at FSU, and the extent to which the disability disables a student from academic activities (compared to the average person) is considered on a case by case basis.

Disabilities Services recommends as a reference the "Policy Statement for Documentation of Attention-Deficit Hyperactivity Disorder in Adolescents and Adults" published by the Educational Testing Service: <http://www.ets.org/distest/adhdplcy.html>. Use of the ETS guidelines will maximize the usefulness of the assessment report. Thank you for your help in providing this information.

- **This form must be completed by a professional qualified by comprehensive training and direct experience in the differential diagnosis of ADHD, i.e. psychologists, neuropsychologists, psychiatrists and other relevantly trained medical doctors.**
- **For a list of qualified professionals in the FSU local area, contact Disabilities Services.**
- **Please provide accurate, comprehensive and legible answers on this form in order to enable our office to determine what auxiliary aids or services are needed.**
- **The evaluator must attach copies or summaries of the specific tests, measures or clinical data used to establish each criterion, and include his or her signature. Please attach extra sheets with supporting verification and explanation for any items which need further interpretation.**

Ferris State University / University College / Department Head
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Verification Form for Documentation of ADD/ADHD

Student: Complete this section.

Last Name _____ First Name _____ M.I. _____

Campus Wide I.D. (CWID): _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize the identified health care provider to release to Disabilities Services the medical information requested on this form for the purpose of determining appropriate accommodation for my ADD/ADHD disability while a student at Ferris State University. I also authorize my provider to discuss my disability with the Disabilities Services Counseling Staff for clarification and continuity of care.

Signature of patient: _____ Date: _____

If under 18 and/or signed by person other than patient, state relationship and authority to do so.

Relationship: _____ Legal Authority: _____

Certifying Professional: Complete this section including the back of this sheet

Today's Date: _____

Printed Name: _____

Signature: _____

Signature denotes: content accuracy, adherence to professional standards and guidelines as stated above.

License Type: _____

License Number: _____ State _____ Exp Date _____

Area of Specialization: _____ Title: _____

Mailing Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Date of Initial Diagnosis: _____

Date of Current Diagnosis: _____



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Which of the following symptoms have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Please characterize symptoms by circling 'Yes' or 'No' and indicating relative severity:

<i>Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often has difficulty sustaining attention in tasks or leisure activities</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often does not seem to listen when spoken to directly</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often does not follow through on instructions and fails to finish schoolwork, tasks, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often has difficulty organizing tasks and activities</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort or that they do not find interesting or easy (such as schoolwork or homework)</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often loses things necessary for tasks or activities (e.g., assignments, pencils, books, or tools)</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Is often easily distracted by extraneous stimuli</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Is often forgetful in daily activities</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often fidgets with hands or feet or squirms in seat</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often leaves seat in classroom or in other situations in which remaining seated is expected</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Subjective feelings of restlessness and an inability to relax</i>
Yes / No Minimal 1 2 3 4 5 Severe



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<i>Often has difficulty engaging in leisure activities calmly</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Is often "on the go" or often acts as if "driven by a motor"</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often talks excessively</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often blurts out answers before questions have been completed</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often has difficulty awaiting turn</i>
Yes / No Minimal 1 2 3 4 5 Severe
<i>Often interrupts or intrudes on others (e.g., butts into conversations)</i>
Yes / No Minimal 1 2 3 4 5 Severe

Adult Specific

Difficulty maintaining relationships with others due to an inability to focus on attention on conversations, "reading" the behavior of others and expressing their own feelings.
Yes / No Minimal 1 2 3 4 5 Severe
Frequent job hopping due to inconsistent work performance, poor organization, lack of time management skills and inability to concentrate on one task at a time.
Yes / No Minimal 1 2 3 4 5 Severe
Tendency to overreact and have a short, quick temper due to becoming easily frustrated and difficulty tolerating stress.
Yes / No Minimal 1 2 3 4 5 Severe
Inability to accurately foresee the consequences of their actions (e.g. engage in risky behaviors such as unprotected sex, alcohol and/or drug use, or unwise financial ventures).
Yes / No Minimal 1 2 3 4 5 Severe

Provide evidence of hyperactive-impulsive or inattentive symptoms that caused impairment were present before 7 years of age. _____



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Provide evidence of impairment from the symptoms in 2 or more settings (e.g., at school, work or at home). _____

Provide evidence that the symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, disassociative disorder, or personality disorder). _____

Code based on type: (Please Circle)

- 314.01** **Attention-Deficit/Hyperactivity Disorder, Combined Type**
- 314.00** **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type**
- 314.01** **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive, Impulsive Type**
- 314.9** **Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified** (Attach detailed explanation)

Describe the student's educational performance history, including previous educational performance, school disciplinary actions, grade repeats, etc. _____

Describe the student's functional limitations on learning and the degree to which it impacts the individual in the academic setting for which accommodations are being requested. _____

List the measures used to assess current educational achievement: (Testing, Grade reports, clinical interviews, etc.)

Describe the presence of compensatory strategies employed by the examinee in any of the DSM-IV diagnostic criteria: _____



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Document all prior accommodations and treatments: _____

Recommendations regarding reasonable academic accommodations: _____

Describe any medication prescribed. What, amount and frequency of administration. _____

Does the student need the above accommodations when utilizing medications? _____

Describe any referrals or suggestions made for further testing, evaluation, treatment or therapy.

Optional Comments: Please use the space below (and additional sheets as needed) to provide any information that will be helpful to Disabilities Services Staff in considering the accommodations you are recommending. _____



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Major Life Activity

For each major life activity listed, denote the level of impact for **both without and with** medication and prescribed aids.

Life Activity		No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentration	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long Term Memory	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short Term Memory	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Major Life Activity Continued

For each major life activity listed, denote the level of impact for **both without and with** medication and prescribed aids.

Life Activity		No Impact	Moderate Impact	Substantial Impact	Don't Know
Managing Internal Distractions	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing External Distractions	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely Submissions of Assignments	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Class Regularly and on Time	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making and Keeping Appointments	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>