DISABILITY VERIFICATION FORM
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
ATTENTION DEFICIT DISORDER (ADD)

Accessibility Services

3501 University Boulevard, East Largo, Suite 2441, Adelphi, MD 20783

Main line: 240-684-2287 Fax: 240-684-2590

To be completed by diagnosing professional

The following student ____________________ has asked to register with Accessibility Services (AS) at University of Maryland Global Campus (UMGC). AS requires GRFXPHQWDWLRQ RI WKH VWXGHQW¶V GLVDELOLW\ LQ RU appropriate services.

Under the Americans with Disabilities Act (ADA) 1990 and Section 504 of the Rehabilitation Act of 1973, students are protected from discrimination and may be entitled to reasonable accommodations. In compliance with the requirements set forth, this form is to verify that a disability exists and accompanying the disability are functional limitations. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and/ or services.

7KH LQIRUPDWLRQ \RX SURYLGH ZLOO QRW EHFRPH D SDUW academic records but will be kept confidential, and placed into WKH VWXGHQW¶V ILOH DW As indicated by the signature below, the student has given permission to release information to UMGC.

Signature of student ____________________________ Date ________________

After completing this form, please mail or fax the form to the address above. If you have any questions regarding the nature of the information requested on this form, please feel free to contact Accessibility Services at (240)684-2287 or accessibilityservices@um

1. DSM-IV Diagnosis:

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Date of initial Diagnosis: ______________________

Last contact with student: ______________________

2.

5. Please provide specific information about the academic limitations and severity of symptoms this student encounters as a result of his/her ADHD.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know

CERTIFYING PROFESSIONAL:

Printed Name and Title:____

Signature/Professional Stamp_________________________________

Date:__________________

License Number:________________________

Address:____

____

Telephone:____________________________   Fax: ___________________

Number of years working with adult college students: _____________