Learning/Psychological/ADHD Disability Documentation

(To be completed by a qualified medical doctor, psychiatrist, counselor, social worker)
~Please type or print neatly/ use a separate sheet if needed, **or provide psychological assessment report**~

Student Name (First, MI, Last) ____

DSM-V: ____

When was the diagnosis made? ____________________ Last date of contact with student: ____________________

Instruments/procedures used to make diagnosis: ____

Level of severity (if applicable) _____Mild _____Moderate ____Severe

If student is taking medications related to this condition, please list medications: ____________________

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If a current treatment plan exists, what is the plan in brief? ____

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Provide a description of the student's functional limitations as a result of this condition, and how they might impact this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others, instructors and students, etc.)

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Suggested accommodations: ____

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Professional's Signature: ______________________________ License #: ____________________

Print or type name and title: ____

Address: ____

Phone: ____________________ Date: ____________________

Direct questions to, or simply submit this form via fax, e-mail or mail to:

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