



## Boston University Disability & Access Services

### Disability Verification Form Attention Deficit /Hyperactivity Disorder (AD/HD)

The Disability & Access Services (DAS) provides academic accommodations and services to students with AD/HD. Students seeking accommodations must provide appropriate documentation of their disability so that DAS can determine the student's eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

To verify the disability and its severity, DAS requires the following current documentation from a physician or other approved specialist with experience and expertise in the area related to the student's disability.

Documentation should include:

- A **current** clear statement of disability including diagnosis and **DSM-5 or ICD Diagnosis (text and code)** and information concerning **co-morbidity**
- Comprehensive **psychoeducational** or **neuropsychological** evaluation not more than three years old and must be based on adult normed testing.
- **Current Functional Limitations:** Information concerning the **impact** of the AD/HD on **major life activities** as well as the **functional limitations** and how they currently interfere in the educational setting. Again, factors to consider include the severity, duration, and pervasiveness of symptoms.
- A narrative **clinical summary** of assessment procedures that were used to make the diagnosis, evaluation results, and list any recommended accommodations.
- Suggested accommodations to address each limitation as well as history of accommodations used.
- The diagnostic report must include the **name, and title, and license number** of the evaluator.
- The evaluation must have been conducted or formally supervised and cosigned by a physician, licensed clinical psychologist, or one who holds a doctorate in neuropsychology, clinical psychology, educational psychology, or other appropriate specialty. Such evaluators are required to have been 1) trained in psychiatric, psychological, neuropsychological and/or psychoeducational assessment; and 2) have at least three years' experience in the evaluation of students with learning disabilities, ADHD/ADD, or psychiatric disabilities.
- A **complete** Disability Verification Form (please do not write "see attached")

**Please note:** all appropriate documentation must be received prior to formal review process commencing. Also please be aware that provision of accommodations in High School, other non BU academic institution or on any standardized test does not guarantee that the same or any accommodations will be awarded at Boston University.

**All documentation is considered confidential and can be mailed or faxed to:**

Disability & Access Services  
25 Buick Street Suite 300, Boston, MA 02215  
Phone: 617-353-3658, Fax: 617-353-9646  
[access@bu.edu](mailto:access@bu.edu) [www.bu.edu/disability](http://www.bu.edu/disability)



## Boston University Disability & Access Services

### Disability Verification Form – AD/HD

This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of AD/HD at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities. Submitting evidence of a diagnosis, IEP, prescription or document showing a discrepancy between ability and achievement on the basis of a single subtest score, is not sufficient to warrant academic accommodations. Similarly, nonspecific diagnoses, such as individual “learning styles,” “learning differences,” “academic problems,” “attention problems,” and “test difficulty/anxiety” in and of themselves do not constitute a disability.

To ensure the provision of reasonable and appropriate accommodations, students requesting academic accommodations must provide current (within the last three years) documentation of the disability. This documentation should provide information regarding the onset, duration and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant adult normed psychoeducational or neuropsychological reports. All information will be kept confidential. Please feel free to contact Disability & Access Services at (617)353-3658 with any questions.

**PLEASE NOTE:** If you do not have current testing please refer to the to our documentation guidelines at: <http://www.bu.edu/disability>.

#### For the student to complete:

Name: (please print) \_\_\_\_\_ BU ID: \_\_\_\_\_

#### For the current treating healthcare provider to complete:

##### 1. Please list all DSM-5 or ICD Diagnoses (text and code):

Diagnoses \_\_\_\_\_

- a. Date diagnosed: \_\_\_\_\_
- b. Date of your last clinical contact with student: \_\_\_\_\_
- c. Current Severity: \_\_\_\_\_

##### 2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- Structured or unstructured interviews with student.
- Interviews with other persons (i.e. parent, teacher, therapist).
- Behavioral observations.
- Neuropsychological testing. Attach documentation.
- Psychoeducational testing. Attach documentation.
- Other (Please specify). \_\_\_\_\_

b. Date of last evaluation \_\_\_\_\_

c. Corroboration of history of childhood onset? Y  N

By whom? \_\_\_\_\_

d. Prognosis of disorder:

Good

Fair

Poor

Please explain: \_\_\_\_\_

\_\_\_\_\_

**3. Functional Limitations** Y  N  If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

a. Please describe in detail any functional limitations that fall into the significant range.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Please list current medications and treatment history.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Special considerations, e.g. medication side effects:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Coexisting Conditions**

Please provide details about any coexisting psychiatric conditions.

Please include all relevant reports.

\_\_\_\_\_  
\_\_\_\_\_

**5. Past Accommodations**

Please indicate whether student has utilized accommodations in the past. Y  N

Please describe: \_\_\_\_\_

\_\_\_\_\_

**6. Suggested Accommodations**

Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

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**Thank you** for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to DAS at the address shown at the end of this document.

**PLEASE NOTE:**

To provide documentation of AD/HD, the evaluation must have been conducted or formally supervised and cosigned by a physician, licensed clinical psychologist, or one who holds a doctorate in neuropsychology, clinical psychology, educational psychology, or other appropriate specialty. Such evaluators are required to have been 1) trained in psychiatric, psychological, neuropsychological and/or psychoeducational assessment; and 2) have at least three years' experience in the evaluation of students with learning disabilities, ADHD/ADD, or psychiatric disabilities.

**Provider Information**

**If submitting electronically, in lieu of signature, please click here to certify that the above statement is true. Document must be in PDF format to be accepted.**

Y  N

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

State of License \_\_\_\_\_: License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Street or P.O. Box City State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please return this signed form to:**

Disability & Access Services  
25 Buick Street  
Suite 300, Boston, MA 02215  
Phone: 617-353-3658  
Fax: 617-353-9646