UCSF Student Disability Services
Student Academic Affairs

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StudentDisability@ucsf.edu | sds.ucsf.edu

VERIFICATION OF DISABILITY: AD/HD

Student Name_____ Birthdate:_____

I am requesting academic support services through the Student Disability Services (SDS) at UCSF. They require current and comprehensive documentation of my AD/HD as one of the criteria used to evaluate my eligibility for disability related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to SDS by mail or fax. I authorize the Student Disability Services at UCSF to contact you if clarification is needed.

Student Signature_____ Date_____

Health Care Provider Name: _____

Title _____

Phone _____ Fax_____

Organization & address _____

The area below must be completed by the Health Care Professional listed above.

Date of diagnosis: _____ Date student last seen: _____

1. DSM IV or V Diagnosis and subtype: _____

2. Present symptoms consistent with the DSM-IV diagnosis (please check all that apply):

   - □ Often fails to give close attention to details or makes careless mistakes
   - □ Often does not follow through on instructions and fails to finish tasks
   - □ Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
   - □ Often does not seem to listen when spoken to directly
   - □ Often has difficulty sustaining attention in tasks
   - □ Often has difficulty with organization
   - □ Often loses things
   - □ Is easily distracted
   - □ Often forgetful in daily activities
   - □ Displays symptoms of hyperactivity and/or impulsivity (e.g., often fidgets, has difficulty remaining seated, experiences feelings of restlessness, excessive talking, blurts out answers before questions completed, etc.)

3. Student displays the following additional symptoms:_____

_____

4. What (if any) other diagnoses are co-existing with the AD/HD diagnosis, which may compound its effect?

_____

5. Treatment and/or medications prescribed (please address side effects/limitations of the medication for this student that could impair academic performance).

_____

_____

6. Impact of the student's symptoms on academic performance

_____

_____

7. Recommendations for reasonable accommodations at the postsecondary level that are supported by the reported symptoms and diagnosis:

_____ Extended time for exams _____ Low distraction room for testing

_____ Note taking services _____ None needed at this time

_____ Other: _____

8. Re-evaluation recommended in (check one): ☐ 6 months ☐ 1 year ☐ other

9. Other relevant comments: _____

_____

_____

Health Care Provider's Signature:

Printed Name: _____ Signature: _____

License Type and Number: _____

Address: _____

Telephone: _____ Fax: _____