

Verification of Attention-Deficit Disorder by a Credentialed Professional

I, _____, hereby authorize _____
of _____
(Facility/Group) (Address) (Phone)

To release my medical information, tests, and/or records to the Center for Accessibility Resources at Saint Xavier University for the purpose of determining my eligibility for disability services.

Signature _____ Date _____

CONFIDENTIALITY: Per the Family Educational Rights and Privacy Act (FERPA), Saint Xavier University's Center for Accessibility Resources upholds the confidentiality of each student's disability-related information. Disclosure of information to any party requires a signed release by the student.

TO THE CREDENTIALLED PROFESSIONAL: To protect the above student from discrimination and determine his/her entitlement to reasonable academic accommodations, current documentation verifying the individual's disability must be provided. Please (1) complete this form in full, (2) provide copies of all relevant tests/reports/case notes, including an interpretative summary, and (3) attach a cover letter on professional letterhead with your title and credentials. Send the collective paperwork to Margaret Rose McDonnell, Director of the Center for Accessibility Resources, at Saint Xavier University via student, email, or mail.

VERIFICATION SUMMARY

1. Date of initial intake: _____ Date of last evaluation: _____
2. Please give a current diagnosis as per the Diagnostic and Statistical Manual-IV (DSM-IV) of the American Psychiatric Association. Include primary and secondary Axis I and Axis II diagnoses and a discussion of dual diagnosis, if present.

- | | | |
|---|-----|----|
| 3. Was the Student evaluated while on medication? | Yes | No |
| 4. Did the prescribed yield a positive response? | Yes | No |

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Center for Accessibility Resources ♦ Margaret Rose McDonnell, Director

3700 West 103rd Street Chicago, IL 60655 ♦ (773) 298-3956 ♦ accessibilityservices@sxu.edu

5. Describe the current functional limitations and/or behavior manifestations and how they hinder the individual's performance of major life activities.

6. What academic accommodations do you recommend? (e.g. assistive devices, support services, compensatory strategies, etc.)

7. Please provide any additional information, such as information about currently prescribed medications, etc., and how they may influence recommended accommodations.

8. Recommended re-evaluation time period or date: _____

CREDENTIALLED PROFESSIONAL:

Name (Print)	Title	License/Certificate Number
<hr/>		
Signature	Date	

Thank you for your time in providing this information.

**Please email or mail this form, all relevant tests/reports/case notes,
and a letterhead with your name/credentials to:**

Margaret Rose McDonnell, Director of the Center for Accessibility Resources

Saint Xavier University

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