DISABLED STUDENT SERVICES
Montana State University in Bozeman
Strand Union Building 155
Bozeman, MT 59717-3960

Voice: (406)994-2824
Fax: (406)994-3943
TTY: (406)994-6701

DISABILITY VERIFICATION - ADHD

The student named below may be eligible for services offered through this office. In order to provide these services, we must have verification of the student's disability.
Please note: The determination of actual services and accommodations will be made by Disabled Student Services.

To be completed by STUDENT (please print legibly in ink):

Student's Name: ____
Last First Middle

Address: ____

____ Phone #: ________________

Social Security #: _______________________ Date of Birth: ____________________

I authorize the release of information requested below to Disabled Student Services at Montana State University at Bozeman. (Your evaluator may have additional releases for you to sign).

____ ___________
Student's Release Signature Date

To be completed by a licensed/certified PROFESSIONAL:

1). Diagnosis: ____

2). Multiaxial DSM-IV classification(s): ____

____

3). Level of severity: _____Mild _____Moderate ____Severe ____Partial Remission

4). Date(s) of diagnosis: _____________________

5). Date of last office visit: ___________________

6). Assessment/evaluation procedures:
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____

-Please continue on back-

7). Relevant background information (i.e., history of disability).

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____

____

8). How does the student’s disability **substantially limit** his/her ability to function in an academic environment?

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____

____

9).What accommodations are recommended in order for the student to access the curriculum and programs at Montana State University?

____

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____

10). Current prescribed medications related to disability:

Medication	Effects/side effects
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (please print): ____

Signature of Professional: ____

License/certification #: ____________________________ Date: ________________

Address: ____

____

Phone #: __________________________ Fax #: __________________________

Return this form to our office as soon as possible so this student may begin participation in our program. Please include any verifying documents from your files.