**Specific Disability Verification:**

**ADHD – Based Disability**

The student named below may be eligible for services offered through the Office of Disability Services at Montana State University-Bozeman. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

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

Phone: ( \_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_

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

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_

**To be completed by a licensed/certified PROFESSIONAL**:

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ /\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Office Visit: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_

Level of severity (circle all that apply): Mild Moderate Severe Partial Remission

Assessment/evaluation procedures:

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

Relevant background information (history of disability):

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

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

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**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.***

|  |  |  |
| --- | --- | --- |
| OFFICE OF DISABILITY SERVICES | Phone: | (406) 994-2824 |
| Montana State University in Bozeman | Fax: | (406) 994-3943 |
| Romney Hall 137 |  |  |
| Bozeman, MT 59717-3960 |  |