Georgian Court University

Accessibility Services

ADD/ADHD Verification Form

Purpose:

This form is to be completed by a qualified licensed professional (e.g., psychologist, psychiatrist, neurologist, or other medical doctor experienced in diagnosing Attention-Deficit/Hyperactivity Disorder) to verify the presence of ADD/ADHD and recommend reasonable accommodations in accordance with the Americans with Disabilities Act ADA , Section 504 of the Rehabilitation Act, and state regulations.

Instructions for the Student:

- Complete Section I.
- Have your clinician complete Section II.
- Submit the completed form to the Office of Accessibility Services.

SECTION I Student Information

(to be completed by student)

Full Name: _____

Date of Birth: _____ / _____ / _____

GCU ID #: _____

Phone: _____

Email: _____

Academic Program/Major: _____

SECTION II Professional Verification

(to be completed by qualified licensed professional)

1. Diagnosis:

Provide DSM 5 diagnosis (include all relevant diagnostic codes):

2. Date of Initial Diagnosis: _____

3. Date of Most Recent Evaluation: _____

4. Describe the student's history as it relates to ADD/ADHD

Include developmental history, relevant medical/educational records, or historical evidence of symptoms.

5. Assessment Procedures Used:

Describe evaluation methods (e.g., rating scales, clinical interviews, neuropsychological or psychoeducational tests).

6. Functional Limitations:

Describe how symptoms of ADD/ADHD significantly impact the student's academic performance or participation.

7. Recommended Accommodations:

List accommodations that may support the student's academic success (e.g., extended time for tests, reduced-distraction environment, note-taking assistance).

Each accommodation must be supported by documented functional limitations.

8. Does the student take any prescribed medications for ADD/ADHD? ☐ Yes ☐ No

If yes, please list medication(s) and indicate if symptoms are adequately managed.

9. Additional Recommendations or Observations (optional):

SECTION III Clinician Information

Name Printed): _____

Title/Profession: _____

License Number and State: _____

Facility/Practice Name: _____

Address: _____

_____

Phone: _____

Email: _____

Signature: _____ **Date:** _____ / _____ / _____

Submit completed form to:

Georgian Court University
Office of Accessibility & Disability Services
900 Lakewood Avenue
Lakewood, NJ 08701

Phone: 732 987 2646 | Email: lfahr@georgian.edu

All information is confidential and maintained in accordance with the Family Educational Rights and Privacy Act FERPA , ADA, and Section 504 regulations.