Georgian Court University

Office of Accessibility Services

Autism Spectrum Disorder Verification Form

Purpose:

This form is to be completed by a licensed professional with training and expertise in diagnosing Autism Spectrum Disorder ASD , such as a psychologist, psychiatrist, neurologist, developmental pediatrician, or other qualified clinician. The purpose is to document the presence of ASD 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 of this form.
- Have your licensed professional complete Section II.
- Submit the fully completed form to the Office of Accessibility Services at Georgian Court University.

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 a DSM 5 diagnosis for Autism Spectrum Disorder, including all relevant diagnostic codes.

2. Date of Initial Diagnosis: _____ 3. Date

of Most Recent Evaluation: _____

4. Assessment Procedures Used:

List and describe diagnostic tools, assessments, clinical interviews, and/or observations used in making the diagnosis.

5. Current Functional Limitations:

Describe how the ASD impacts the student's daily functioning, particularly in the academic setting (e.g., communication, social interaction, executive functioning, sensory processing, etc.).

6. Recommended Academic Accommodations:

List accommodations that are necessary for the student to have equal access to educational opportunities. Each accommodation must be directly supported by the functional limitations noted above.

Examples may include:

- Extended test time
- Alternative testing environment
- Note-taking assistance
- Preferential seating
- Use of assistive technology

Recommended accommodations:

7. Medications (if applicable):

Is the student currently prescribed any medications related to their diagnosis?

☐ Yes ☐ No

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

8. Additional Comments or Recommendations:

Include any other information that may assist Georgian Court University in providing appropriate support.

SECTION III Clinician Information

Name Printed): _____

Title/Profession: _____

License Number and State: _____

Practice/Agency Name: _____

Phone: _____

Email: _____

Address: _____

_____

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 documentation submitted is maintained confidentially and used solely for the purpose of determining eligibility for reasonable accommodations under FERPA, ADA, and Section 504 guidelines.