

AUGSBURG
C O L L E G E

CLASS
Supplemental Verification Form
for Attentional and Psychiatric Disabilities

The student named below is requesting accommodations due to the impact of a disability. To evaluate that request, our office requires that the following form be completed by a qualified professional who has first-hand knowledge of the student's condition and is **an impartial individual** not related to the student.

Documentation must provide evidence that the disability substantially limits a major life activity, such as learning. The provision of reasonable accommodations is based on assessment reports and the **current impact** of the disability on academic performance.

It should be noted that academic accommodations are intended to ensure access to educational opportunities for students with disabilities, not to make adjustments that would fundamentally alter the nature of the course, course components, or course requirements.

Certain sections of this verification may not apply to all students. The completed form should be faxed or mailed to the CLASS office (contact information below).

Student Information (The student should complete this section.)

Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth ____/____/____ Phone _____

Certifying Professional (This section is to be completed by a qualified professional)

Print Name _____

Professional Title _____

License/Certification Number and Issuing State _____

Initial Contact with Student ____/____/____ Last Contact with Student ____/____/____

Multi-Axial DSM-IV Diagnosis:

Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses.

*For ADHD/ADD: full assessment reports are required with this verification

	<i>Diagnoses</i>	<i>Age at onset (if known)</i>	<i>Comments</i>
Axis I	_____	_____	_____
Axis II	_____	_____	_____
Axis III	_____	_____	_____
Axis IV	_____	_____	_____
Axis V	_____	_____	_____

Date of Diagnosis ____ / ____ / ____

Please list the DSM-IV diagnostic criteria that were identified as present in this case: _____

Please describe the settings in which these symptoms have been most evident.

If the diagnosis includes a phobic response to exams, does this problem limit the student's demonstration of their knowledge of the class material on a non-accommodated exam?
_____ Yes _____ No
Explanation _____

Academic and Therapeutic Interventions

Please describe academic interventions, coaching support or other behavioral programs that have been made available and their level of effectiveness (if applicable) _____

Planned therapeutic interventions (if applicable) _____

Current compliance with therapeutic interventions _____

Prognosis for therapeutic interventions (Include likelihood of improvement or deterioration and within what approximate timeframe.) _____

Does this person currently pose a threat to him/herself or to others? If so, please specify.

History of hospitalization (as related to diagnoses) _____

Medications

Current medication(s) including dosage, effectiveness and side effects _____

Long-term medication plan _____

Current compliance with medication plan _____

Prognosis for medication plan (Include likelihood of improvement or deterioration and within what approximate timeframe.) _____

Impact of Condition on Educational Success

Please identify the **specific academic abilities or functions** that are compromised by the disorder. Indicate severity of these limitations _____

Please specify the **impact of the disorder and prescribed medications** upon exams and other classroom activities. _____

Suggested Accommodations

NOTE: *Final determination of appropriate accommodations will be determined by CLASS in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation must be accompanied by an explanation of its relevance to the diagnosed disability.*

Extended time to complete exams _____ Yes _____ No
Why? _____

Quiet room in which to take exams _____ Yes _____ No
Why? _____

Other accommodations (Please specify) _____ Yes _____ No
Why? _____

Signature of Professional _____	Date _____
Agency _____	
Address _____	
City _____	State _____ Zip Code _____
Phone _____	Fax _____

Thank you for your assistance in completing this form.