

CERTIFICATION OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER

The person identified below has applied for admission to the Learning Disabilities Program at Adelphi University. To determine this applicant's eligibility for admission to the Program, we require documentation of Attention Deficit/Hyperactivity Disorder by a credentialed professional.

Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To determine eligibility under the law, documentation must indicate that a specific disability exists and that it significantly limits one or more major life activities. A diagnosis in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please mail or Fax it to us at the address above. The information you provide will not become part of the student's educational record, but will be kept in the student's file in the Learning Disabilities Program, where it will be held strictly confidential. In addition to the requested information, please attach any other information you think would be relevant to the applicant's admissions file and/or to their academic experience. Thank you for your support of this person's application.

Applicant's Name: _____

Today's Date: _____ Date of Diagnosis: _____

Date Applicant was last seen: _____

Applicant is seen: Occasionally Regularly As Needed

DSM-IV Diagnosis:

Axis I:		Clinical Disorders
Axis II:		Personality Disorders, Mental Retardation
Axis III:		General Medical Conditions
Axis IV:		Psychological and Environmental Problems

1. In addition to DSM-IV criteria, how did you arrive at your diagnosis? Please check all that apply below, and add a descriptive statement for each item checked. This information will help us determine appropriate accommodations and services for the student.

Structured or unstructured interviews with the person himself or herself.

Interviews with other persons.

Behavioral observations.

Developmental history.

Family history.

Educational history.

Medical history.

Neuro-psychological testing. **Please attach a copy of the testing.**

Psycho-educational testing. **Please attach a copy of the testing.**

Standardized or un-standardized rating scales. **Please specify which scales.**

Other. **Please specify.**

2. Please check level of limitation in the following major life activities:

Life Activity	No Impact	Mild Impact	Moderate Impact	Substantial Impact	Don't Know
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Internal Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing External Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely Submission of Assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Class Regularly and On Time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making and Keeping Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. What other specific symptoms manifesting themselves at this time might affect the applicant's academic performance?

4. Is this student taking medication(s) for AD/HD? Describe the medications, dates prescribed, effect on academic functioning, and side effects. Do limitations/symptoms persist even with medication?

5. Is there anything else you think is important for us to know about this applicant?

CERTIFYING PROFESSIONAL	
Print Name:	_____
Signature:	_____
License #:	_____
Address:	_____ _____
Telephone:	_____
Fax:	_____
Email:	_____