CAPE COD COMMUNITY COLLEGE
O'NEILL CENTER FOR STUDENT ACCESS AND SUPPORT

2240 Iyanough Rd. West Barnstable, MA 02668-1599
(508) 375-4110 (Fax)

VERIFICATION OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

DATE: ______________________

TO: ______________________

FROM:

__ Richard H. Sommers, Ph.D.
Learning Disabilities Specialist
Lic. Clinical Psychologist
rsommers@capecod.edu
(508) 362-2121 Ext. 4317

__ Douglas Terry
Coordinator, Disability Services
dterry@capecod.edu
(508) 362-2131 Ext. 4337

___________________________ is a student at Cape Cod Community College who is requesting academic accommodations/services through our Office. In order to determine this student's eligibility for academic adjustments/modifications under the Americans with Disabilities ACT, and to ensure the provision of such services, the College requires documentation of the disability. Your assistance in furnishing pertinent psychological/medical information that would enable us to accurately assess this student's special needs would be greatly appreciated. ***NOTE: See reverse side of this form for questionnaire to be completed by an appropriate practitioner.***

Academic accommodations for students with ADHD may include priority registration, extended time on exams, books on CD, tutors, word processing and adaptive computer technology. Each student is assessed on his/her special needs with appropriate documentation.

Student authorization to release information

I hereby authorized the above named psychologist/psychiatrist/neurologist to release information regarding my disability to the O'Neill Center at Cape Cod Community College. I understand that the information will be used for documentation of my disability and to ensure the provision of reasonable and appropriate services. Furthermore, I understand all information provided will be held in strict confidence as specified in the rules and regulations of Cape Cod Community College.

Student Signature: ____ Date: _________________________

Patient's name:____

Psychological/Medical Information to Document ADHD

(Attention Deficit Hyperactivity Disorder)

To Be Completed By Psychiatrist/ Clinical Psychologist/ Neurologist/ Psychiatric Nurse Practitioner

1. DSM-V/DSM-IV (or ICD-10) Classification:____

2. DSM-V/DSM-IV Criteria (or ICD-10 symptoms) related to diagnostic category.
   (Describe the symptoms, severity and longevity of the condition related to and that substantiate the diagnostic category.)

3. Date of onset, last date patient seen, type of evaluation conducted, and treatment plan. If no treatment is being provided, please explain why the condition is severe enough to be considered a disability.

4. List medications and any side effects that maybe important in developing an education plan.

5. You may offer suggestions for appropriate and reasonable accommodations at the post-secondary educational level.

Signature: ____________________________________ Date:____________________________

Print Name and Title: ____

Address:____

____ Phone:__________________________