



# UNIVERSITY OF DALLAS

Student Disability Services ♦ Haggar 253  
1845 East Northgate Drive ♦ Irving, Texas 75062 ♦ [www.udallas.edu/sds](http://www.udallas.edu/sds)  
Phone (972) 721-5056 ♦ Facsimile (972) 265-5712 ♦ Email [ada@udallas.edu](mailto:ada@udallas.edu)

## STUDENT DISABILITY SERVICES VERIFICATION FORM FOR STUDENTS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER AND PSYCHOLOGICAL DISABILITIES

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided.

- Please refer to the “Guidelines for Documenting Psychological Disabilities” or “Guidelines for Documenting Attention-Deficit/Hyperactivity Disorder” for comprehensive documentation requirements and additional information.
- To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current (within the last 12 months for Psychological and 3 years for ADHD) documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement.
- Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. • To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation.

All information will be kept confidential. Please feel free to contact the ADA/Section 504 Coordinator at (972) 721-5056 with questions.

***The information below and the release of information on the second page are to be completed and signed by the student.***

\_\_\_\_\_  
Student Name UD ID

\_\_\_\_\_  
Student Signature Date

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*If the information above is left blank or is incomplete it may delay or prevent SDS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.*



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## CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

Pursuant to Federal and State law concerning my right to confidentiality and privileged communication, I

\_\_\_\_\_ authorize:

\_\_\_\_\_  
Person or Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

### To release the following information:

- \_\_\_\_\_ Information Requested on this Verification Form
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Psych-Educational/Neuropsychological Evaluations
- \_\_\_\_\_ Psychological Evaluation
- \_\_\_\_\_ History of previously used accommodations
- \_\_\_\_\_ Other: \_\_\_\_\_

Documentation needed to request academic, dietary, and/or housing accommodations at post-secondary institution.

### The information is to be provided to:

Student Disability Services, Braniff  
132 University of Dallas  
1845 East Northgate Drive  
Irving, Texas 75062  
Phone: (972) 721-5056  
Fax: (972) 265-5712  
Email: [ada@udallas.edu](mailto:ada@udallas.edu)

### Purpose of disclosure:

*I understand this authorization for confidential information applies only to the individual named above and only for a period of 180 days and does not permit the release of information concerning me to any other individual. In addition, I understand I may revoke this consent to release information at any time, but recognize that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.*

A photocopy or fax of this authorization shall be considered as effective and valid as the original. Student

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ UD

Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_





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**Functional Limitations:** *Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.*

1. Does this condition significantly limit one or more of the following major life activities?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

2. Please check the functional limitations or behavioral manifestations for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				

Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

3. Please describe in detail any functional limitations that fall into the substantial range.

\_\_\_\_\_ 4.

Special considerations, e.g. medication side effects:

\_\_\_\_\_  
 \_\_\_\_\_



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## Accommodations

1. Please mark whether student has utilized accommodations in the past.

- Yes- Please describe: \_\_\_\_\_
- No
- Don't Know

2. Recommended accommodations. Please provide a rationale for each accommodation. In the absence of a rationale, Student Disability Services may be unable to recommend the proposed accommodation:

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3. Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

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4. **COURSE LOAD REDUCTION:** Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- Yes
- No
- I don't know

If YES please explain: \_\_\_\_\_

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*Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document.*

***All documentation submitted to SDS is considered confidential.***

### ***Provider Information***

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name and title: \_\_\_\_\_

State of License : \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Street or P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Please return this form to:**

University of Dallas  
Student Disability Services  
Braniff 132  
1845 East Northgate Drive  
Irving, Texas 75062  
Phone: (972) 721-5056  
Facsimile: (972) 265-5712

***Attach Provider Business Card Here***

[Adapted from <https://diversity.utexas.edu/disability/wp-content/uploads/2018/07/Medical.VerForm-2015-Updated.pdf>, with permission from ITS, The University of Texas at Austin, Austin, Texas 78712-1110.]

