

ADHD VERIFICATION FORM

Student Name and ID#: _____

Date of Birth: _____ Phone: _____ BC email: _____

The following information is to be completed by a qualified health professional and either returned directly to Accessibility Resources or the student. This information will be used to assist Broward College in determining appropriate accommodations.

| | |
|---|--------------------------|
| Type of ADHD | |
| Diagnostic Code | |
| Circle One | Mild Moderate Severe |
| Date of Diagnosis | |
| How long has the student been your patient? | |

Please attach any information that will assist Broward College with determining appropriate accommodations for this student, such as case notes, direct observations, psychological evaluations, or other test results.

 Signature

 Date

 Print Name, Title, License Number

 Address and Phone Number