

**AUTISM SPECTRUM DISORDERS 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.

Specific Diagnosis on the Spectrum	
Diagnostic Code	
Circle One	Mild   Moderate   Severe
Date of Diagnosis	

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