

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