Resource Center for Persons with Disabilities (RCPD)

Maximizing Ability & Opportunity

Michigan State University

434 Farm Lane #120 Bessey Hall

East Lansing, MI 48824-1033

(517) 884-RCPD (517) 432-3191 (fax)

rcpd.msu.edu



**DISABILITY DOCUMENTATION FORM:**

**attention deficit hyperactivity disorder (ADHD)**

# PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Resource Center for Persons with Disabilities (RCPD) at Michigan State University. Michigan State University provides academic and workplace services and accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the RCPD can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

*The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.” Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.*

**Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information on official letterhead to the RCPD by a licensed psychologist, neuropsychologist, psychiatrist, or other relevantly trained medical doctor**. Professionals completing this form must have first-hand knowledge of the condition, experience in working with students and employees with ADHD and ideally a familiarity with the physical, emotional and cognitive demands experienced by students and employees in an academic setting. Diagnoses of disabilities documented by family members are unacceptable. A diagnostic evaluation must have been completed within the last five years. For additional information regarding documentation guidelines, refer to the **Educational Testing Services** (ETS) guidelines at [www.ets.org](http://www.ets.org) or [www.eeoc.gov](http://www.eeoc.gov).

**All aspects of this form must be completed for documentation to be considered complete.**

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

**Client Information**

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

Client name: Last First Middle Initial

Date of Birth: \_\_\_\_\_\_\_\_ Client’s MSU NetID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certifying Professional**

Certifying Professional’s Printed Name:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentials/Specialization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Exp. Date \_\_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |
| --- | --- |
| |  | | --- | | Attach Business Card Here  or  If Submitting Electronically,  Denote your Office Web Address | |

Office web address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Code based on type: (Please check the appropriate diagnosis and attach supporting documents)** |
| 314.01 (F90.2) ADHD, Combined Presentation |
| 314.00 (F90.0)  ADHD, Predominantly Inattentive Presentation |
| 314.01 (F90.1)  ADHD, Predominantly Hyperactive/Impulsive Presentation |
| 314.01 (F90.8) Other Specified ADHD |
| 314.01 (F90.9) Unspecified ADHD |
| **Level of severity- Check one:**  Mild Moderate  Severe |
| **Date of Onset: Date of current diagnosis:** |

|  |
| --- |
| **Other diagnoses:** Please include DSM or ICD Codes and name of any other relevant diagnoses that may impact your client’s work or school performance: |
|  |
| **Date of Onset: Date of current diagnosis:** |

**Diagnostic Tools:** How did you arrive at your diagnosis/diagnoses? Please check any relevant items below and **attach assessment(s) to this form**:

|  |  |
| --- | --- |
| Interviews with the client | Interviews with other persons |
| Behavioral observations | Developmental history |
| Psycho-educational testing | Neuro-psychological testing |
| High School 504 Plan | Self-rated or interviewer rated scales |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Medication, Treatment, and Prescribed Aids**

What treatment, medication and prescribed aids are currently being used to address the diagnosis/diagnoses listed above?

Fully describe the impact of medication side-effects that may adversely affect the client’s academic or workplace performance:

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

**Date of last appointment:** ­­­

How often does your client receive treatment?

Weekly Monthly Annually As needed

**Implications for Workplace or Academic/Student Life**

Disabilities involve ongoing substantial limitations and are distinct from temporary or common conditions not substantially limiting major life activities.

The Americans with Disabilities Act (ADA) defines disability as *“a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.”*

Identify below any functional limitations/restrictions that remain and impact major life activities even with the treatment listed previously.

|  |  |  |
| --- | --- | --- |
| **Major Life Activity** | **Impacts**  Please check the severity of impacts | **Explanation of Impact**  Please describe how your client’s condition impacts each major life activity and include examples relating to workplace or academic/student life. |
| Concentration | None  Moderate  Substantial  Unsure |  |
| Memory | None  Moderate  Substantial  Unsure |  |
| Time Management and Organization | None  Moderate  Substantial  Unsure |  |
| Eating/Sleeping | None  Moderate  Substantial  Unsure |  |
| Task Initiation and Completion | None  Moderate  Substantial  Unsure |  |
| Listening | None  Moderate  Substantial  Unsure |  |
| Social Interactions | None  Moderate  Substantial  Unsure |  |
| Academic Tasks (Reading, Mathematics, Writing) | None  Moderate  Substantial  Unsure |  |
| Managing Internal Distractions | None  Moderate  Substantial  Unsure |  |
| Managing External Distractions | None  Moderate  Substantial  Unsure |  |
| Work and Managing Personal Affairs | None  Moderate  Substantial  Unsure |  |
| Stress Management | None  Moderate  Substantial  Unsure |  |
| Other (Explain):  \_\_\_\_\_\_\_\_\_\_\_\_ | None  Moderate  Substantial  Unsure |  |

Please print this documentation, sign and date below. Send or fax directly to RCPD using the contact information on page one.

**Date:**

**Certifying Professional’s Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.**

**Additional/Secondary Certifying Professional’s Signature (if applicable):**

**My Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.**