2100 16th Avenue South
Great Falls, MT 59405
406-771-4311
FAX: 406-771-4342

Disability Verification for Psychiatric, ADD/ADHD, and Learning Disabilities

Please assist us in providing appropriate educational services for this student by verifying their diagnosis (diagnoses). In addition, please tell us how the student's disability may affect their ability to function in an academic environment and any accommodations that you believe will assist the student in the tasks of learning.

Release of Information

To be completed by the student (Please print legibly in ink):

Student's Full Name:
Date of Birth:

Student Release Signature

I authorize the release of information requested below to the Office of Academic Success and Accessibility at Great Falls College, Montana State University. (Your evaluator may have additional releases for you to sign).

Student's Release Signature:
Date:

All the information below must be completed by a licensed/certified professional

(Please use additional pages as needed)

1. Diagnoses:
2. Duration:
3. Level of Severity:
4. Dates of Diagnoses:

Please help the Office of Academic Success and Accessibility at Great Falls College Montana State University to provide the most helpful and effective educational environment for your client/patient. Take a few moments to consider and answer the following two questions.

How does the student's disability substantially limit their ability to function in an academic environment (i. e. mobility, attendance, classroom activities, test taking, etc.)?

What are some accommodations that will help the student with tasks such reading taking tests, paying attention in class, note-taking, etc.?

Please include a psychological evaluation or psycho-educational evaluation for LD & ADD/ADHD if available. The report should include the following:

- Assessment/evaluation procedures along with scores of all tests administered
- Relevant background information (i.e., history of disability)

Additional comments:

Licensed Professional Signature

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Printed name of professional:

Signature of professional:

Professional Credential:
License/certification number:
Street address:
City: State: Zip:

Please return this form as soon as possible so this student may receive accommodations.
Please include the necessary verifying documents from your files.