

**Lake Michigan College Student Outreach and Support Services
Serving Benton Harbor, South Haven, and Niles Campuses
2755 E. Napier Ave Benton Harbor, MI 49022
Phone: (269) 927-8866 Fax: (269) 927-6536**

**DISABILITY DOCUMENTATION FORM:
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)**

PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Student Outreach and Support Services (SOSS) at Lake Michigan College. Lake Michigan College provides academic accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the SOSS 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 SOSS 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 with ADHD and ideally a familiarity with the physical, emotional and cognitive demands experienced by students and in an academic setting. Diagnoses of disabilities documented by family members are unacceptable. **This form must be completed by a professional qualified by comprehensive training and direct experience in the differential diagnosis of ADHD (e.g. psychologists, neuropsychologists, psychiatrists and other relevantly trained medical doctors).**

- **The individual must provide recent documentation verifying the condition and describing its current functional impact. In most cases, this means that a diagnostic evaluation must have been completed within the last three years.**
- **Please provide accurate, comprehensive and LEGIBLE answers on this form in order to expedite the process and enable SOSS to determine what auxiliary aids or services are needed. ALL ASPECTS OF THIS FORM MUST BE COMPLETED FOR DOCUMENTATION TO BE considered complete.**
- **Evaluators desiring an alternative to this form may provide equivalent information including a psychological report which provides a list of specific tests and the scores used to establish a diagnosis. Please attach extra sheets with supporting verification and explanation for any items which need further interpretation.**

Client Information

Client name: Last First Middle Initial

Date of Birth: Client's LMC Student ID (eight digits):

Certifying Professional

Certifying Professional's Printed Name:

Credentials/Specialization:

License Type:

License #: State: Exp. Date:

Mailing Address:

City/State/Zip:

Phone: () Fax: ()

Email:

Office web address:

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

Code based on type: (Please check the appropriate diagnosis and attach supporting documents)	
<input type="checkbox"/>	314.01 (F90.2) ADHD, Combined Presentation
<input type="checkbox"/>	314.00 (F90.0) ADHD, Predominantly Inattentive Presentation
<input type="checkbox"/>	314.01 (F90.1) ADHD, Predominantly Hyperactive/Impulsive Presentation
<input type="checkbox"/>	314.01 (F90.8) Other Specified ADHD
<input type="checkbox"/>	314.01 (F90.9) Unspecified ADHD
Level of severity- Check one: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Date of Onset:	Date of current diagnosis:
Please identify any other relevant diagnosis that may impact your client's work or school performance.	

DIAGNOSTIC TOOLS: Please identify the diagnostic tools you used to determine this diagnosis. Summarize the scores and results of the evaluation, conclusions and implications. Please attach extra sheets with supporting verification and explanation for any items which need further interpretation.

Medication, Treatment, and Prescribed Aids

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

Implications for Academic/Student Life

Major Life Activity	Impact Please describe the impact of your client's condition as it applies to each major life activity.	Recommendations for Accommodations and Services Please provide specific recommendations to address impacted major life activities.
Concentration		
Listening		
Academic Tasks (Reading, Mathematics, Writing)		
Staying on Task and Completing Tasks		
Taking Lecture Notes		
Conversations		
Time Management and Organization		
Managing External Distractions		
Memory		
Social Interaction		
Eating/Sleeping		
Work and Managing Personal Affairs		
Other (Explain): _____		

Using the contact information on page one, print, sign below, and fax/send directly to the Student Outreach and Support Services.

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