CARROLL UNIVERSITY
Walter Young Center

ACADEMIC ACCOMMODATIONS REQUEST
ADHD/Psychological Disability Documentation

(To be completed by a qualified medical doctor, psychiatrist, counselor, social worker)
Please type or print neatly/ use a separate sheet if needed

Student Name (First, MI, Last) _____ D.O.B: _____

DSM-5: _____

When was the diagnosis made? _____Last date of contact with student: _____

Instruments/procedures used to make diagnosis: _____

_____

Level of severity (if applicable) ____Mild _____ Moderate ____Severe

If student is taking medications related to this condition, please list medications: _____

_____

_____

If a current treatment plan exists, what is the plan in brief?_____

_____

_____

Provide a description of the student's functional limitations as a result of this condition, and how they might impact this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others, instructors and students, etc.) _____

_____

_____

_____

Suggested accommodations: _____

_____

_____

Professional's Signature:_____ License #:_____

Print or type name and title: _____

Address: _____

Phone: _____ Date: _____

Direct questions to, or simply submit this form via fax, e-mail or mail to:

Martha Bledsoe, Director Services of Students with Disabilities
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