WICHITA STATE UNIVERSITY
Office of Disability Services

Documentation of Learning / ADHD Disabilities
(To be completed by a qualified professional.)

Date:
Student Name: ________________________________________________________________
Home Address: ________________________________________________________________
          City_____________        State____________          Zip Code____________
Telephone: (________)_____________________
Student signature to release requested information: __________________________

The above student has requested that you complete the following information to verify their disability. To ensure the provision of reasonable and appropriate services for students with psychological disabilities, students needing such services are required to provide current and comprehensive documentation of their disability. We ask that you complete the following sections or provide a written report that addresses all the areas listed below. Any information you can provide that offers recommendations for necessary and appropriate auxiliary aids or service, academic adjustment, or other accommodation is appreciated.

Date of Diagnosis ____________________

Diagnosis (DSM criteria) ______________________________________________________
________________________________________________________________________

Tests & Scores used to determine diagnosis.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Diagnostic Interview Summary
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Wichita State University, Wichita, Kansas 67260-0132 Voice/TDD (316) 978-3309 Fax (316) 978-3114
Level of Severity (circle one)    Mild    Moderate    Severe

Measures used to assess the following if applicable.

Aptitude
________________________________________________________________
________________________________________________________________
________________________________________________________________

Achievement
________________________________________________________________
________________________________________________________________
________________________________________________________________

Information Processing
________________________________________________________________
________________________________________________________________
________________________________________________________________

Social – Emotional
________________________________________________________________
________________________________________________________________
________________________________________________________________

Provide a summary of the student’s educational, medical, and family history that may relate to Learning / ADHD disability.
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

QUALIFIED PROFESSIONAL’S SIGNATURE ________________________________

PRINTED NAME AND TITLE ___________________________________________

ADDRESS: __________________________________________________________

DAYTIME TELEPHONE: (___)________________________

Return this form to

Wichita State University
Director, Disability Services
1845 Fairmount
Wichita, KS 67260-0132