Southeast Arkansas College Office of Disability Services
Attention Deficit/Hyperactivity Disorder Documentation Request Form

<table>
<thead>
<tr>
<th>Southeast Arkansas College</th>
<th>870-850-2183</th>
<th>Counselor</th>
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</thead>
<tbody>
<tr>
<td>Office of Disability Services</td>
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<tr>
<td>Student Affairs Division</td>
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</tbody>
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| Today’s Date: ___________________________________________ |
| Student’s Name: __________________________________________ |
| Home Address: ____________________________________________ |
| Telephone: ______________________________________________ |

The Southeast Arkansas College student named above is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations due to AD/HD from the Office of Disability Services (ODS). In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, College Policy requires that a qualified professional provide current and comprehensive documentation of AD/HD. A qualified professional includes a psychiatrist, psychologist, medical doctor or other qualified healthcare professional who is not a family member of the student. In order to be considered current, the qualified professional’s statement must be within 6 months prior to the date of the most recent request from ODS.

The documentation provided must include information that diagnoses the AD/HD, describes the functional limitations in an educational setting, and indicates the severity and longevity of the AD/HD for the purpose of determining academic adjustment(s) or other accommodation(s). IEP’s and other generalized pieces of information will not be adequate.

Under the Americans with Disabilities Act and the Rehabilitation Act of 1973, an individual with a disability means any person who:

1. Has a physical or mental impairment which substantially limits one or more major life activities;
2. Has a record of such an impairment; or
3. Is regarded as having such impairment, whether he/she has the impairment or not.

“Major life activities” include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others.

**Please provide the following information:**

Diagnosis (as diagnosed by the DSM-IV):
______________________________________________________________
______________________________________________________________
______________________________________________________________

Date of Diagnosis: ________________ Date of Last Contact with Student: ________________

Revised 10_2013
Prognosis:

_________________________________________________________

Describe the student’s functional limitations or restrictions in an educational setting, if any:

_________________________________________________________

_________________________________________________________

Expected date restrictions will be lifted, if any:

_________________________________________________________

Describe clinical evidence of disability, i.e. physical findings, x-rays, lab tests:

_________________________________________________________

_________________________________________________________

_________________________________________________________

Please indicate the recommendations you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student’s educational opportunities at SEARK College as justified based on the functional limitations indicated above.

_________________________________________________________

_________________________________________________________

_________________________________________________________

Qualified Professional’s Signature:

_________________________________________________________

Printed Name & Title:

_________________________________________________________

Daytime Telephone Number: ________________________________

Address: ________________________________________________

Date: ____________________________________________________

Return this information marked confidential to:
Office of Disability Services
Counselor
SEARK College
1900 Hazel Street
Pine Bluff, Arkansas  71603
Notes: It may be necessary to re-submit documentation for conditions not of a chronic nature. Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.