ACCESSIBILITY SERVICES OFFICE
HARVARD UNIVERSITY DIVISION OF CONTINUING EDUCATION
Harvard Extension School * Harvard Summer School
51 Brattle Street, Cambridge, Massachusetts 02138 – 3722
(Phone) (617) 998-9640 * (Fax) (617) 410-4069 * accessibility@extension.harvard.edu

Learning Disabilities and Attention Deficit Hyperactivity Disorder Provider Verification Form

The information supplied on this verification form should reflect the current impact on your patient/client's condition. The LD/ADHD Provider Verification form should be returned to the Accessibility Services Office (ASO) of Harvard University's Division of Continuing Education. This form is to be completed by the clinician. Please be aware that information which is incomplete or illegible may require additional follow-up from the ASO.

Your client/patient may qualify for reasonable accommodation pursuant to the Americans with Disabilities Act (ADA). We are seeking your professional input in order to determine if your client/patient qualifies as disabled and, if so, what reasonable accommodations may be necessary and appropriate for accessing the School's programs and activities. In responding below we request information about the nature of the impairment(s), its impact on the student's major life activities and to what degree.

Date:_____
Student Name: DOB:_____
Last:_____ First:_____ M.I.:_____

Date of initial contact with student/patient:_____
Date of onset of the condition:_____
Patient was last seen on: _____

Please list diagnosis(es), functional limitations (Fl) and level of severity *compared with most people in the general population*	**Severity of Dx Frequency of Sx**		
Dx 1)	Mild	Moderate	Severe
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Dx 2)	Mild	Moderate	Severe
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Fl:	☐	☐	☐

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Dx 3)	Mild	Moderate	Severe
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Dx 4)	Mild	Moderate	Severe
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Dx 5)	Mild	Moderate	Severe
Fl:	☐	☐	☐
Fl:	☐	☐	☐
Fl:	☐	☐	☐

Please provide information on the process of evaluation to arrive at the diagnosis.

Please state any recommended accommodations or modifications you believe would be *necessary* to ensure equal access for this student in an educational environment:

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Please provide information you believe to be relevant that we did not request:

Provider Information:

Provider Name (print):_____
Provider Signature:_____

License or Certification #:_____ State:_____

Address:_____

Phone:_____ Email:_____

Release of Information:

I _____ hereby release my confidential medical information to Harvard University's Division of Continuing Education, Accessibility Services Office for the purpose of obtaining accommodations related to a disability. If information contained in this document is unclear, I hereby give permission to the Accessibility Services Office and my provider named herein permission to discuss my medical situation.

Signed: _____ Date:_____

This release of information is permissible until: (date)_____ or, one year from the date signed.