

ARO is located on the ground floor of the Library, L017. For appointments and information, call 607-778-5150, VP 607-238-2714 or email aro@sunybroome.edu

ADHD Provider Form

Students with documented long-term or permanent disabilities or serious medical conditions may qualify for equal access accommodations. In lieu of documentation of diagnostic testing, students may submit this form in order to establish eligibility with an ADHD diagnosis.

This form must be submitted by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title, and license or certification credentials must be stated in the documentation, dated, and signed. Forms completed by relatives will not be accepted.

Forms may be completed electronically, but must include either an **original signature** or **office stamp** to be authenticated. **FORMS WITHOUT THESE WILL NOT BE REVIEWED.**

Student Information

1. Student's Legal Name: _____
2. Student's Preferred Name and Pronouns: _____
3. Student's Date of Birth: _____
4. Student's SUNY Broome B#: _____

Provider/Student Relationship

1. How long have you been working with the student? _____
2. When did you last see the student? _____

Diagnostic Information

3. Does the student have a confirmed diagnosis of ADHD? YES NO
4. Were you the provider who diagnosed the student with ADHD? YES NO

If No, can you confirm the student's ADHD diagnosis? YES NO

5. Does the student have any additional diagnoses? YES NO UNKNOWN

If yes, please list:

6. How was the diagnosis of ADHD determined and when? Please indicate if testing was a comprehensive psychological evaluation, checklist, self-report, or derived in any other means:

7. Please describe the functional impact experienced by the student in relation to their ADHD diagnosis as it pertains to an **academic setting** (e.g., impact on studying, test taking, note-taking):

8. Please describe the functional impact experienced by the student in relation to their ADHD diagnosis as it pertains to **daily living** (e.g. eating, sleeping, transportation, recreation):

9. Please describe all current treatments and management strategies (e.g., medication, stress-reduction, diet, resources, coping strategies):

Provider's Contact Information:

1. Name and credentials: _____
2. Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): _____
3. Address: _____
4. Fax and/or email address: _____
5. Telephone Number: _____
6. Professional Signature: _____
7. License Number and State: _____
8. Date: _____

If you would like a fillable version of this document, please contact the Accessibility Resources Office at aro@sunybroome.edu