

Verification Form: Learning Disorders

Rev. 01.22.2025

Albright College's Student Accessibility and Advocacy (SAA) office has established verification forms to assist in obtaining current information from a qualified professional (e.g., medical physician, neurologist/neuropsychologist, clinical psychologist, licensed counselor, or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional treating this individual for at least three months. To assist the student, we need to understand the student's symptoms, relevant medications and their impact on the student, and the student's need for accommodations. This verification form may supplement information provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores.

Any documentation must meet Albright College's documentation standards for the student's condition. A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Documentation must show evidence of a disability as defined by the ADA.
- Documentation must be no more than 3 years old except in rare circumstances.
- Documentation must describe functional impairment affecting an important life skill and how this affects the student in the college environment.
- Documentation must provide history relevant to the student's disability, including treatments, assistive devices, or other pertinent information.
- Documentation must establish a clear link between the recommended accommodation and the student's functional limitations.
- Documentation must present a summary and recommendations.

(Please **print legibly** or **type**; illegible documents will not be processed)

Student Information

Student's Name: _____ DOB: _____

Home Address: _____

Local Address (if different): _____

Cell Phone: _____ Other Phone: _____

Provider Section

Date of Initial Contact with Student: _____

Date of Most Recent Contact with Student: _____

Diagnosis

What is the student's primary diagnosis? _____ DSM-5/ICD-11: _____

Descriptive Features: _____

How long have you been treating the student for THIS condition? _____

How often is the student seen for THIS condition? (e.g., weekly, monthly) _____

Does the student have an educational history of a learning disorder? No Yes

If yes, at what age/grade level did the student begin to exhibit apparent difficulty learning academic skills? _____

Has the student demonstrated persistent difficulty learning academic skills, for at least six months, despite targeted interventions in the areas of academic difficulty? No Yes

Please check all areas where performance is significantly below age-appropriate expectations:

- Word decoding and reading fluency
- Reading comprehension
- Spelling
- Writing difficulties such as grammar, punctuation, organization, clarity
- Number sense, fact and calculation
- Mathematical reasoning

(Please **print legibly** or **type**; illegible documents will not be processed)

Diagnosis (cont'd)

Did you use objective and statistically sound assessments to evaluate the student’s learning difficulties?

- No Yes

If yes, please provide information below regarding the student’s global intellectual function and current academic functioning as measured by aptitude and achievement tests. **If this information is contained in a neuropsychological or psychoeducational evaluative report, please submit the report with this form.**

The following section may be skipped if a report is attached.

Aptitude – please include:

- the name of the comprehensive and current aptitude/cognitive instrument administered.
- the standard scores per subtest.
- the percentiles per subtest.

Achievement – please include:

- the name of the comprehensive and current achievement instrument administered.
- the standard scores per academic subtest.
- the percentiles per academic subtest.

If you did not administer diagnostic testing, how did you reach your conclusion about the learning disorder and necessary interventions and academic accommodations?

(Please print legibly or type; illegible documents will not be processed)

Diagnosis (cont'd)

WHODAS 2 score (if given): _____

Please provide information regarding any secondary diagnosis/es the student may have:

Diagnosis: _____

DSM-5/ICD-11 _____ Severity of impairment: _____

Descriptive features: _____

Diagnosis: _____

DSM-5/ICD-11 _____ Severity of impairment: _____

Descriptive features: _____

Diagnosis: _____

DSM-5/ICD-11 _____ Severity of impairment: _____

Descriptive features: _____

Is there any other historical information relevant to the student's learning disorder(s) and associated functioning (e.g., developmental, familial, pharmacological, psychological, psychosocial)

(Please print legibly or type; illegible documents will not be processed)

Current Symptoms

Is there clear evidence that the student's learning difficulties are interfering with or reducing the quality of at least one of the following within the academic environment? No Yes

If yes, please explain in the space provided.

Academic functioning:

Social functioning:

Workplace functioning:

Language functioning:

Alternative explanations - Please check all that can be noted as contributing to the student's learning difficulties:

- Intellectual disability
- Visual or hearing impairment
- Psychological disorder (e.g., depression, anxiety)
- Neurological disorder
- Psychosocial difficulty
- Language differences (i.e., English as a second language)
- Lack of access to adequate instruction

(Please print legibly or type; illegible documents will not be processed)

Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis you are treating, or any other medications, that may impact the student's ability to function in the college environment? No Yes

If yes, please provide information below for each medication the student is prescribed.

Medication/dosage/frequency: _____

Date first prescribed: _____

Side effects that impact the student's functioning (e.g., concentration, sleep, eating):

Medication/dosage/frequency: _____

Date first prescribed: _____

Side effects that impact the student's functioning (e.g., concentration, sleep, eating):

Medication/dosage/frequency: _____

Date first prescribed: _____

Side effects that impact the student's functioning (e.g., concentration, sleep, eating):

Medication/dosage/frequency: _____

Date first prescribed: _____

Side effects that impact the student's functioning (e.g., concentration, sleep, eating):

(Please print legibly or type; illegible documents will not be processed)

Functional Limitations and Recommended Accommodations

It is important for us to understand how the student’s current symptoms cause functional impairments in a college environment. Accommodations are not based on the student’s diagnosis/es or medication(s) but on the limitations of their functioning in the educational environment. Based on your knowledge of the students, please provide information regarding reasonable academic accommodations and the rationale for each accommodation based on the student’s symptoms

Learning difficulty: _____

How does this affect the student?

Recommended reasonable accommodation:

Learning difficulty: _____

How does this affect the student?

Recommended reasonable accommodation:

Learning difficulty: _____

How does this affect the student?

Recommended reasonable accommodation:

(Please print legibly or type; illegible documents will not be processed)

Provider's Certifying Information

Professionals rendering assessments and diagnoses and providing recommendations for reasonable accommodations must be relevant and qualified to do so (medical doctor, neurologist/neuropsychologist, psychologist, licensed counselor). The provider signing this form MUST be the same person who answered the questions above, and may NOT be related to the student.

Provider's signature: _____ Date signed: _____

Provider's name (printed): _____

Credentials: _____

License number: _____ State of licenser: _____

Office or business name: _____

Street address: _____

Office phone: _____ Fax: _____

email address: _____

Directions for Submitting This Form and Supporting Documentation

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA Office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

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