# Certification Of Attention-Deficit Disorder / Hyperactivity Disorder

**Disabled Students' Program**
University of California, Berkeley
260 César E. Chávez Student Center
Berkeley, CA 94720-4250
Phone: (510) 642-0518 (Voice/TTY)
Fax: (510) 643-9686

The student named below has applied for services from the Disabled Students' Program (DSP) at UC Berkeley. In order to determine eligibility and to provide services, we require documentation of the student's Attention-Deficit/Hyperactivity Disorder (ADHD). After completing this form, please print it out, sign it, and mail or fax it to the address above. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file at DSP. In addition to the requested information, please attach all supportive information, reports, and test results relevant to the documented diagnosis and limitations.

**Student's Name: _____ UC Berkeley Student ID #: _____ (Required)**

**Today's Date: _____/_____/_____**
Month Day Year

1. **DSM-5:** Please include all relevant diagnostic information including subtypes and/or specifiers for diagnostic domains and subgroups (as indicated in DSM-5) including V/Z codes: psychosocial and environmental stressors.

| | |
|---|---|
| Focus of Clinical Treatment: | Please select *one* response below that is the most appropriate ADHD diagnosis:<br>____ADHD 314.00 (F90.0) Predominantly inattentive presentation<br>____ADHD 314.01 (F90.1) Predominantly hyperactive/impulsive presentation<br>____ADHD 314.01 (F90.2) Combined presentation<br>____ADHD 314.01 (F90.8) Other specified ADHD<br>____ADHD 314.01 (F90.9) Unspecified ADHD |
| Secondary Diagnoses: | |
| Medical Conditions: | |

2. Date of above diagnosis: _____/_____/_____
Month Day Year

3. Date student was last seen: _____/_____/_____
Month Day Year

4. In addition to DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items below, **adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student**.

Structured or unstructured interviews with the student

Interviews with other persons

Behavioral observations

Developmental history

Educational history

Medical history

Psycho-educational testing. Date(s) of testing? If applicable, please include testing.

Standardized or nonstandardized rating scales

Other (Please specify)

5. Please provide specific information about the academic limitations and severity of symptoms this student encounters as a result of AD/HD.

| **Life Activity** | **No Impact** | **Moderate Impact** | **Severe Impact** | **Don't Know** |
|---|---|---|---|---|
| Organization | | | | |
| Concentration | | | | |
| Activation/initiating to work | | | | |
| Sustained focus | | | | |
| Memory | | | | |
| Stress management | | | | |
| Timely submission of assignments | | | | |
| Understanding directions | | | | |
| Managing internal distractions | | | | |
| Managing external distractions | | | | |
| Specific academic topics: | | | | |
| • Math | | | | |
| • Reading | | | | |
| • Written expression | | | | |
| • Other (please describe) | | | | |

6. Is the student taking medications for ADHD? ☐ Yes ☐ No

Describe medications(s), date(s) prescribed, effect on academic functioning, and side effects

Do limitations/symptoms persist even with medications? ☐ Yes ☐ No

7. Is the student currently in treatment with you? ☐ Yes ☐ No

8. Other information: Is there anything else you would like us to know about this student?

**Certifying Professional**

| | |
|---|---|
| Signature of Professional | Date |
| Professional's Name (printed) and Title | License No. |
| Address | Telephone Number |
| City, State, ZIP Code | Fax Number |

I request that the information below be provided to DSP in order to determine my eligibility for the program and to obtain program services

Signature of Student Date

I authorize DSP and University Health Services to coordinate relevant information when necessary to support the efficient provision of DSP services and health care services on my behalf. This authorization will remain valid for the duration of my time as a student at UC Berkeley. I understand I may revoke this authorization at any time by submitting a written request to revoke to Disabled Students Program or University Health Services.

Signature of Student Date