# UNIVERSITY OF NORTH FLORIDA

**Student Accessibility Center**

Building 57, Room 1500

1 UNF Drive

Jacksonville, Florida 32224-2665

Tel: (904) 620-2769 FAX: (904) 620-3874

 SAC@unf.edu

## Disability Verification of Autism Spectrum Disorder

Documentation must be provided by one of the following licensed mental health professionals: Psychologist, Psychiatrist, Clinical Social Worker, Mental Health Counselor, Psychiatric Nurse Practitioner (ANCC).

### Student complete the following as a release for evaluator.

* Student Name:
* Date of Birth:
* Phone Number:
* UNF Student N Number (if assigned one):

**To ensure the provision of appropriate accommodations, you must provide current documentation of your disability. This documentation should provide information regarding the onset, longevity and severity of symptoms as well as a specific description of how they interfere with educational achievement. Assessment of current functioning is necessary.**

The following information will assist us in providing the most appropriate academic accommodations for you. We are required to maintain confidential records for the purpose of academic accommodation according to Section 504 of the Vocational Rehabilitation Act of 1972 and the Americans with Disabilities Act of 1990.

I hereby authorize the following information as well as any other pertinent documentation to be forwarded to the Student Accessibility Center at the University of North Florida for the purpose of determining my eligibility for academic accommodations.

* Student Signature:

* Date:

Information to be requested from Professional.

* Professional’s Name:
* Address:
* City:
* State/Zip:
* Phone Number:

### AUTISM SPECTRUM DISORDER DOCUMENTATION FORM (To Be Completed by Certifying Professional)

* **Student’s Name:**
* **Date of Birth:**

The student named above is applying for disability accommodations and/or services through the Student Accessibility Center (SAC) at the University of North Florida. In order to determine eligibility, a qualified professional must certify that the student has been diagnosed as having Autism Spectrum Disorder and must provide evidence that it represents a substantial impediment to a major life activity. It is important to understand that a diagnosis in and of itself does not substantiate a disability. This documentation form was developed as an alternative to a traditional diagnostic report. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the SAC website in order to view documentation guidelines. Please consider the following as you fill out the form. Thank you.

* The form should be completed with as much detail as possible as a partially completed form or limited responses will hinder the eligibility process.
* The assessment information is current - For students just graduating high school, an evaluation reflecting current levels of academic skills should have been administered while in high school. For students who have been out of school for a number of years, documentation will be considered on a case by case basis.
* The form is completed by a professional who has comprehensive training and direct experience in the differential diagnosis such as a psychologist, neurologist or psychiatrist.
* The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

### What is the DSM-V diagnosis for this student?

* Axis I:
* Axis II:
* Axis III:
* Axis IV:
* Axis V (GAF score):
* Date of last contact with student:
1. How long has the student had this diagnosis/condition?
2. What are the student’s primary current symptoms and concerns?
3. What is the severity of the symptoms; mild, moderate or severe?
4. Explain the severity indicated in the previous question:
5. **Date(s) current assessment completed:**
6. State the frequency of appointments with student (e.g., once a week, twice a month):
7. **Psychological History** – Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable):

**Psychosocial History** – Provide pertinent information obtained from the student/parent(s)/guardian(s) regarding the student’s psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk- taking or dangerous activities, etc.):

### Certifying evaluator complete the following.

1. **State the student’s functional limitations from the disorder specifically in the college setting:**
2. Other pertinent information:
3. State the student’s relevant current medication(s), including dosage, frequency, and adverse side effects:
4. Provide an explanation of the extent to which the medication currently mitigates the symptoms of the condition:
5. **State specific recommendations regarding academic adjustments, housing accommodations, auxiliary aids, and/or services for this student and the reason these academic adjustments, housing accommodations, auxiliary aids, and/or services are warranted based upon the student’s functional limitations.**
6. **Should the student be exempt from living on campus and/or having a meal plan? Explain.**

Please use the following scale to indicate the impact the student’s condition has on the particular activity of behavior listed next.

The numeric scale is: 1 is very low, 2 is low, 3 is medium, 4 is high and 5 is very high. Abbreviate 'DK' for 'Don't Know'.

* Activity of Behavior **Social interaction**, impact level number is:
* Activity of Behavior **Social awareness**, impact level number is:
* Activity of Behavior **Oral expression**, impact level number is:
* Activity of Behavior **Listening comprehension**, impact level number is:
* Activity/Behavior **Completing tasks independently**, impact level number is:
* Activity of Behavior **Organization**, impact level number is:
* Activity of Behavior **Distractibility**, impact level number is:
* Activity of Behavior **Adherence to strict routines**, impact level number is:
* Activity of Behavior **Sensory sensitivity**, impact level number is:
* Activity of Behavior **Repetitive behaviors**, impact level number is:
* Activity of Behavior **Time management**, impact level number is:
* Activity of Behavior **Mathematics**, impact level number is:
* Activity of Behavior **Reading**, impact level number is:
* Activity of Behavior **Writing**, impact level number is:
* Any **Additional** Activity/Behavior:
* impact level number is:

### Certifying Professional Information

* Name and Title:
* Date:
* License or Certification Number:
* Company/Office/Institution Affiliation Name:
* Address:
* City:
* State, Zip:
* Phone Number:
* Fax Number:
* Signature of Certifying Professional:

Thank you for your prompt response to this request. Please return any pertinent information to:

Rusty Dubberly, Ed.D.

Director, Student Accessibility Center

Building 57, Room 1500

1 UNF Drive

Jacksonville, Florida 32224-2665

Tel: (904) 620-2769 FAX: (904) 620-3874

E-mail: [Rusty Dubberly](file:///%5C%5Coak%5CDepts%5CADACompliance%5CADA%20Audit%20for%20Document%20Compliance%5CDRC%5Cr.dubberly%40unf.edu)(r.dubberly@unf.edu)