

**SUMMARY FOR ADHD DOCUMENTATION**

**STUDENT**

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date(s) of evaluation: \_\_\_\_\_

**CERTIFYING PROFESSIONAL**

Name \_\_\_\_\_

Professional title \_\_\_\_\_ Highest degree \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

License/certification, number and state \_\_\_\_\_

**Diagnosis(es):**

\_\_\_\_\_  
\_\_\_\_\_

Conditions/causes ruled out: \_\_\_\_\_

In your opinion, does any condition listed above *substantially limit a major life activity* and thereby rise to the level of disability?

Yes  No  Not sure

If yes, indicate which one(s) with an asterisk above and indicate the major life activity(ies) here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommended Accommodations, if any:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Include a description of specific functional limitations and a rationale for each suggested accommodation in the full report.*

In your opinion, does this individual represent a potential danger to self or others, *including patients under his or her care in a medical setting*?  Yes  No  Not sure

*Please explain a "yes" or "no/sure" in your full report or on separate letterhead.*

Signature \_\_\_\_\_ Date \_\_\_\_\_