LEARNING DISABILITIES VERIFICATION FORM

Special Services at Macomb Community College provides services to students with diagnosed learning disabilities. To determine eligibility, this office requires current and comprehensive documentation of the disorder or disability from the diagnosing physician, psychiatrist, fully-licensed psychologist, social worker or licensed professional counselor.

Information shared with this office is confidential. All records are housed in the Special Services Office at Macomb Community College and are not part of the student's academic record.

To ensure our office provides appropriate support for the student, please complete this form online at www.macomb.edu keyword search: verification form. If it is necessary to complete this form by hand, please print neatly.

Last Name: ____________ First Name: ____________ Initial: ____

Birth Date: ____________ Date of Diagnosis: ____________

DSM-IV-TR Diagnosis:

Level of Severity (mild, moderate, severe):

Indicate additional diagnosis (i.e. depression, bipolar, anxiety, ADD/ADHD):

Indicate instruments and/or procedures used in diagnosis. (Please attach a copy of report or evaluation. Check all that apply:

- ☐ Clinical Interview
- ☐ Developmental & educational history
- ☐ KTEA
- ☐ Medical Evaluation
- ☐ Neuropsychological & psycho-educational testing
- ☐ Rating Scales
- ☐ WAIS or WISCIII Academic Test
- ☐ WIAT
- ☐ Woodstock-Johnson Battery
- ☐ Other:

List any current treatments, medications (including dosages, frequency and side effects), devices, or services the student is receiving. Has the student adhered to the medication / treatment?

Indicate the student's functional limitations in educational settings. Indicate presence of issues in time management, organization, reading and studying, recall and writing speed during examinations, reading speed and comprehension, and difficulty with task completion.

Please indicate accommodations that may be helpful for the student. Each recommendation should include an explanation of its relevance to the diagnosis or area of functional limitation.

Professional Signature Date

Printed name and title

Address City State Zip Code

Phone Number Fax Number e-mail address

Thank you for assisting us in developing a level of support that will allow the student to take full advantage of college life at Macomb Community College. Any further information you may feel important to share is appreciated.

Please return this form to one of our offices below.

Macomb Community College Center Campus
ATTN: Special Services
44575 Garfield Road
Clinton Township, MI 48038-1139
Phone: 586.286.2237
Fax: 586.286.2295
TTY: 586.286.2238
Direct VP (Deaf): 866.957.1377
Local VP (Hearing): 586.649.3942

Macomb Community College South Campus
ATTN: Special Services
14500 E. 12 Mile Road
Warren, MI 48088-3896
Phone: 586.445.7420
Fax: 586.498.4033
TTY: 586.445.7498
Direct VP (Deaf): 866.957.2172
Local VP (Hearing): 586.447.7936

Release of Information

I,

, hereby authorize the exchange and release of the above confidential information to the Special Services Office at Macomb Community College for the purpose of determining my eligibility for educational accommodation.

Student Signature Date

Witness Signature Date