

# Verification Form

## Specific Learning Disabilities

Bucks County Community College’s Accessibility Office (TAO) has established the Verification Form for Specific Learning Disabilities to obtain current information from a qualified practitioner (e.g., psychologist, neuropsychologist) regarding a student’s learning disorder symptoms and their impact on the student and his or her need for accommodations. This Verification Form should supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College’s TAO guidelines for Specific Learning Disabilities. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting Specific Learning Disabilities can be found at the following web site: <http://www.bucks.edu/student/accessibility/student-info/>. A summary of the guideline criteria for documenting Specific Learning Disabilities is as follows:

1. Persistent learning difficulties and academic performance below expectations as measured by objective and statistically sound assessments of aptitude and achievement
2. Educational history of learning difficulties
3. Functional limitations affecting an important life skill, including academic functioning
4. Exclusion of alternative diagnoses or attributing factors
5. Summary and recommendations

### Section I: Student Information (Please type information or print legibly)

**Student Name:** \_\_\_\_\_  
Last First Middle

**Student ID:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Bucks Email:** \_\_\_\_\_ **Home Email:** \_\_\_\_\_

**Permanent Street Address:** \_\_\_\_\_  
 \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Local Street Address:** \_\_\_\_\_  
 \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

### Section II: Provider Section (Please type information or print legibly)

#### A. Contact with the Student:

**Date of initial contact with the student:** \_\_\_\_\_

**Date of last contact with the student:** \_\_\_\_\_

#### B. Diagnosis Information:

##### 1. Educational History

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

Approximately at what age or grade did the student start to exhibit apparent difficulty learning academic skills? \_\_\_\_\_

What date was the student diagnosed with specific learning disability symptoms?  
 \_\_\_\_\_  
Month Year

What date or grade was the student diagnosed with a learning disorder? \_\_\_\_\_

Please include any historical information relevant to the student’s learning disorder and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

**2. Impact of Learning**

Has the student demonstrated a persistent difficulty learning academic skills (for at least  Yes  NO six months) despite targeted intervention(s) in the area(s) of academic difficulty?

**Please check all areas of the student’s documented academic skill difficulties that are substantially below expectations given the student’s age:**

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

Did you use objective and statistically sound assessments to evaluate the student’s learning difficulties?  Yes  NO

**If yes, please provide information regarding the student’s global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively. This information can be attached to this Verification Form if contained within a neuropsychological or psychoeducational evaluative report (please include this report with the Verification Form).**

**Aptitude:**

**List the name of the comprehensive and current aptitude/cognitive instrument administered**

**List the standard scores per subtest; and (c) the percentiles per subtest**

<b>Achievement:</b>	
<b>List the name of the comprehensive and current achievement battery administered</b>	
<b>List the standard scores per academic area subtest</b>	
<b>List the percentiles per academic area subtest</b>	

**If no, how did you reach your conclusion about the learning disorder and necessary interventions and academic accommodations?**

**3. Functional Impairment:**

Is there clear evidence that the student’s learning difficulties are interfering with or reducing the quality of at least one of the following, including academic functioning?

<b>Environmental Functioning:</b>	
School functioning:	
Social functioning:	
Work functioning:	

Please check all that can be attributed to the student's academic and learning difficulties:	
<input type="checkbox"/>	Intellectual disability
<input type="checkbox"/>	Visual or hearing impairment
<input type="checkbox"/>	Psychological disorder (e.g., depression, anxiety, etc.)
<input type="checkbox"/>	Neurological disorder
<input type="checkbox"/>	Psycho-social difficulty
<input type="checkbox"/>	Language differences (i.e., English as a second language)
<input type="checkbox"/>	Lack of access to adequate instruction

**6. DSM Codes:** Please include all pertinent diagnoses or rule-out diagnoses using DSM codes.

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Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (GAF):	

**C. Medications:**

1. Is the student currently taking medication(s) for SPECIFIC LEARNING DISABILITIES symptoms?  Yes  NO

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

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

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

<b>Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):</b>	
<b>Date Prescribed:</b>	
<b>Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.):</b>	

**D. Functional Limitations and Recommended Accommodations:**

1. Please list the student’s current Specific Learning Disabilities symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.
2. **Sample:** A student requires great effort to read class materials and completes reading assignments at a slow rate.

<b>Symptom: (Example)</b>
Slow, effortful reading
<b>Recommended Reasonable Accommodation(s):</b>
Textbooks and written classroom materials in alternative format to be read by text-to-speech software

<b>Symptom:</b>
<b>Recommended Reasonable Accommodation(s):</b>

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### Section III: Provider’s Certifying Professional Information:

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., psychologist, neuropsychologist). The provider signing this form must be the same person answering the above questions.

**Provider’s Name:** \_\_\_\_\_  
Last First Middle

**Credentials:** \_\_\_\_\_

**License Number:** \_\_\_\_\_ **State of Licenser:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Practice Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

May this completed Verification Form be released to the student?  Yes  NO

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

**Email:** [accessibility@bucks.edu](mailto:accessibility@bucks.edu)

**Fax:** (215) 968-8033

**USPS:** Bucks County Community College  
Attention: The Accessibility Office  
275 Swamp Road  
Newtown, Pennsylvania 18940

**Physical Drop Off:** Newtown Campus  
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at <http://www.bucks.edu/student/accessibility/>. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.

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