Autism Spectrum Disorders Verification Form

Student Name and ID#: ____________________________________________________

Date of Birth: _______________ Phone: _______________ BC email: _____________________________________

The following information is to be completed by a qualified health professional and either returned directly to
Accessibility Resources or the student. This information will be used to assist Broward College in determining
appropriate accommodations.

Specific Diagnosis on the Spectrum ____________________________________________

Diagnostic Code ___________________________________________________________________________

Circle One: Mild Moderate Severe

Date of Diagnosis ____________________________________________

Please attach any information that will assist Broward College with determining appropriate accommodations for this
student, such as case notes, direct observations, psychological evaluations, or other test results.

_______________________________________________________________ 
Signature Date

______________________________________________________________
Print Name, Title, License Number

_______________________________________________________________
Address and Phone Number

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