

FORM EIGHT

**JOHN MARSHALL LAW SCHOOL
ACCOMMODATIONS REQUEST VERIFICATION FORM
[To be completed by physician or licensed professional]**

PART I – TO BE COMPLETED BY JMLS STUDENT:
Name: _____ S.S. # _____
Year: _____ Full-time _____ Part-time _____
Local Address: _____
Work Telephone: _____ Home Telephone: _____
Mobile Phone: _____ E-mail: _____

PART II – PHYSICIAN OR LICENSED PROFESSIONAL:
Name: _____ Title: _____
Address: _____
Office Telephone: _____ Office Fax: _____
Other Phone: _____ E-mail: _____

Briefly describe this diagnosis: _____

Treatment consisted of: _____

Last date of treatment/consultation date with student: _____

Explain the specific condition or physical problem that requires academic accommodations: _____

Is this a permanent condition/disability? Yes No

If No, when is the condition/disability likely to abate? _____

In what way does the condition/disability affect the applicant's ability to read/write/concentrate for extended periods of time? _____

Based on the student's condition/disability and your diagnosis, what academic accommodations would you recommend? **[Check all that would apply.]**

- Regular Print Test Books
- Large print (18pt.) test books
- Rest time during examinations
- Additional testing time – **Please specify:** _____ If a specific amount or proportion of additional testing time is NOT indicated, additional testing time will not be made available.
- Use of reader
- Test room and restrooms accessible by wheelchair
- Non-distractive test room
- Use of a tape recorder (Used as a backup only for dictated writing sample)
- Use of medications
- Use of magnifying glass
- Use of scratch paper
- Other – **Please specify:** _____

Please describe your credential(s) allowing you to verify this person's disability: _____

I certify that all the information on this form is true and correct to the best of my knowledge and belief.

Signature

Date

Georgia License/Certification Number

Please note: Pages 3 & 4 must be completed if applicant has a learning disability. Information may be reviewed by a learning specialist. Accommodations may not be appropriate unless this information is provided.

LEARNING DISABILITY VERIFICATION FORM
[To Be Completed By A Qualified Medical Professional]

Student Name: _____ S.S. # _____

DIRECTIONS:

A student with a specific learning disability must have been identified by a psycho-educational assessment process which includes data from both cognitive and achievement measures. Testing must also:

- Have been administered within the last five (5) years;
- Identify an information processing deficit; and
- Identify an aptitude-achievement discrepancy of 1.5 standard deviations.

Indicate below the specific tests and scores used to identify the specific learning disabilities.

COGNITIVE ASSESSMENT:

Date Cognitive Assessment Completed: _____

WECHSLER ADULT INTELLIGENCE SCALE-REVISED(WAIS-R)

Verbal _____ Performance _____ Full Scale _____

SCALED SCORES:

Information _____	Picture Completion _____
Digit Span _____	Picture Arrangement _____
Vocabulary _____	Block Design _____
Arithmetic _____	Object Assembly _____
Comprehension _____	Digit Symbol _____
Similarities _____	

Mean (X) of scaled scores: _____ Performance _____

**WOODCOCK-JOHNSON PSYCHO-EDUCATIONAL BATTERY-REVISED-PART 1;
COGNITIVE:**

STANDARD SCORES ONLY:

Full Scale Broad Cognitive _____	Processing Speed _____
Reading Aptitude _____	Auditory Processing _____
Math Aptitude _____	Visual Processing _____
Written Language Aptitude _____	Short Term Memory _____
Other _____	Other _____

PROCESSING DEFICIT ASSESSMENT:

Test	Sub-Test	Standard/Scaled Scores
WAIS-R	_____	_____
	_____	_____
	_____	_____
WOODCOCK JOHNSON-R	_____	_____
	_____	_____
OTHER	_____	_____

ACHIEVEMENT ASSESSMENT:

Date Achievement Assessment Completed: _____

Test	Sub-Test	Standard Score
WOODCOCK JOHNSON-R	_____	_____
	_____	_____
WRAT	_____	_____
	_____	_____
NELSON-DENNY	_____	_____
	_____	_____
OTHER	_____	_____

APTITUDE-ACHIEVEMENT DISCREPANCY:

Aptitude Measure/Subtests

	Standard Score
_____	_____
_____	_____
Achievement Measure/Subtests(s)	_____
_____	_____

Summary of Diagnosis: _____

I certify that all the information on this form is true and correct to the best of my knowledge and belief.

Signature

Date

Georgia License/Certification Number