Use of AI in Documentation Fabrication

Survey to gather insights from accommodation professionals on whether they: 1) have concerns related to the use of artificial intelligence (AI) to generate/falsify documentation for the purposes of accessing academic accommodations; 2) have encountered documentation submitted for the purposes of obtaining academic accommodations that they were concerned may be fraudulent/created by AI; and 3) whether they have policies in place to address the identification and consequences of submitted documentation that may have been generated or falsified using AI.

Complete the survey!

What Screening Tools Can—and Can't—Tell Us About Neurodevelopmental Conditions

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Regional Assessment Resource Centre (RARC)

RARC is a Centre of Excellence housing clinical psychologists, educators, transition specialists and researchers.

Services provided under 4 pillars:

Transition

Research

Training

Assessment

Outline:

1. Understand the role of screening tools in detecting neurodevelopmental disorders
2. Review commonly used screeners
3. Provide practical recommendations for the use of screening measures
4. Review SEND

The Role of Screening Measures

- Screening tests are not designed to diagnose but rather to identify individuals whose symptoms require more careful evaluation.
- Because screening tests are often used to identify uncommon disorders (e.g., ones with a low base rate) the cut scores suggested for use on these tests are designed to err on the side of caution, overidentifying many more people than truly have the condition.
- By contrast, because these screening tests are overly sensitive, they rarely miss those who are symptomatic.

Psychometric Principles Refresher

- All tests function on probabilities; a screening test provides the user with a score that is felt to maximize the probability that a true positive case will not be missed while ensuring that very few individuals with a negative score are really symptomatic.
- **Sensitivity** is the actual percentage of true positives; how many known positive cases the test detects. In essence, it answers the question, ***"I already know that my client has the illness in question. What is the chance that this test will show that my client has it?"***

Psychometric Principles Refresher

- **Specificity**, by contrast, is the actual percentage of true negatives; how many known negative cases are correctly classified as such using this test. In essence, it answers the question, ***"I already know that my client does not have the illness in question. What is the chance that this test shows my client does not have it?"***
- However, when evaluating a client in one's office, the clinician does not already know what the true answer is (e.g., they don't know for certain whether the client has the illness or not), and so they rely on the test scores to help decide whether a client's symptoms are consistent with a particular diagnosis.

Psychometric Principles Refresher

- To obtain this type of clinical information, one must instead know the positive predictive value (PPV) and negative predictive value (NPV) of a given test; these predictive values are influenced heavily by the base rate of the disorder or illness within a specified population.
- The **PPV** answers the question, ***"my client just tested positive on this test. What is the chance that my client truly has this illness?"*** The **NPV**, by contrast, answers the question, ***"my client just tested negative on this test. What is the chance that my client does not have this illness?"*** As one can see, these are clinically relevant questions asked by most evaluators completing diagnostic evaluations.

Clinical Example

- Assume that you have 60 adults whom you know have ADHD (based on gold standard diagnostic procedures).
- You administer a new ADHD self-report measure to these adults as well as to 60 adults whom you know do not have ADHD.
- The new test correctly identifies 90% of your ADHD sample as having ADHD and 72% of your non-ADHD group as not having ADHD. Hence, sensitivity is 90% and specificity is 72%.

Clinical Example

- In order to evaluate how the new test functions clinically (when the true diagnosis is not known), we would need to evaluate how the new test performs in a population in which only 5% of people have the condition.
- Using the 90% specificity and 72% sensitivity values obtained when testing against the gold standard, we can calculate the PPV and NPV of this new test when the base rate of ADHD is 5%.
- Thus, out of 1,000 people only 50 truly have ADHD (e.g., 5%) and 950 do not. However, the clinician does not know who has the condition and who does not, and so we use our new test to make this determination.

Clinical Example

Table 2. Ability of New Test to Correctly Identify ADHD When Base Rate is 5%.

		Results of new ADHD self-report measure		
		Test Says Not ADHD	Test Says ADHD	Total
Actual diagnosis/reality	Not ADHD	684	266	950
	ADHD	5	45	50
	Total	689	311	1,000

- With a known sensitivity of 90% (e.g., I already know you do have ADHD, and 90/100 times the test gets it right) the new ADHD test will correctly identify 45/50 individuals as having ADHD.
- However, applying specificity of 72% to these data (e.g., I already know that you don't have ADHD, and for the 950 people without ADHD the test gets it right 72% of the time), we can see that the new test also falsely identifies 266 not ADHD adults as having ADHD. In other words, for every 311 people the test identifies as ADHD, it is wrong 266 times

Clinical Example

- Hence, when the base rate of a condition is low, the false positive rate of the screening test will be high.
- Here, at a base rate of 5%, the false positive rate of the test is 86% (266 of the 311 adults are incorrectly identified by the test as ADHD), whereas the false negative rate is less than 1%.
- This analysis shows how the base rate of a condition influences the diagnostic accuracy of any screening test, and why PPV and NPV are important statistics to know clinically when interpreting the results of any screening test.

Screening Tools for ADHD

Journal of Attention Disorders
1–17

DOI: 10.1177/10870547231177470
journals.sagepub.com/home/jad
Sage

The Ability of Self-Report Methods to Accurately Diagnose Attention Deficit Hyperactivity Disorder: A Systematic Review

Allyson G. Harrison[1] and Melanie J. Edwards[1]

Abstract

Objective: To identify and analyze all studies validating rating scales or interview-based screeners commonly used to evaluate ADHD in adults. **Method:** A systematic literature search identified all studies providing diagnostic accuracy statistics, including sensitivity and specificity, supplemented by relevant articles or test manuals referenced in reviewed manuscripts. **Results:** Only 20 published studies or manuals provided data regarding sensitivity and specificity when tasked with differentiating those with and without ADHD. While all screening measures have excellent ability to correctly classify non-ADHD individuals (with negative predictive values exceeding 96%), false positive rates were high. At best, positive predictive values in clinical samples reached 61%, but most fell below 20%. **Conclusion:** Clinicians cannot rely on scales alone to diagnose ADHD and must undertake more rigorous evaluation of clients who screen positive. Furthermore, relevant classification statistics must be included in publications to help clinicians make statistically defensible decisions. Otherwise, clinicians risk inappropriately diagnosing ADHD. *(J. of Att. Dis. XXXX; XX(X) XX-XX)*

Screening Tools for ADHD

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____ **Date Completed:** _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					

Screening Tools for ADHD (ADHD/No ADHD): ASRS

# Items/ Scale Used	Cut Score Used	Sen (%)	Spe (%)	Estimated rate of ADHD: 5% PPV (%)	5% NPV (%)	10% PPV (%)	10% NPV (%)
18 (*A* + *B*)	Total score ≥ 35	80	88	26	99	43	98
	Total score ≥ 21	95	45	8	99	16	99
	Total score ≥ 16	98	22	6	100	12	99
6 items (Part A)	≥ 4/6 questions endorsing sometimes/ often/very often for questions 1 to 3; and endorsing often/very often for questions 4 to 6	69	99.5	88	98	94	97
18 items (*A* + *B*)	≥ 9/18 items endorsing sometimes/ often/very often for questions 1 to 3, 9, 12, 16, & 18; and endorsing often/ very often for remaining questions	56	98	60	98	76	95

Screening Tools for ADHD (ADHD/Other Condition): ASRS

				Estimated Rate of ADHD			
				5%		10%	
# Items/ Scale Used	Cut Score Used	Sen (%)	Spe (%)	PPV (%)	NPV (%)	PPV (%)	NPV (%)
6 items (Part A)	Total score ≥ 14	60	69	9	97	18	94
		92	27	6	98	12	97
		90	35	7	99	13	97
		84	66	12	99	22	97

Screening Tools for ADHD (ADHD/No ADHD): CAARS-S

Short Form

ADHD Index subscale	$T \geq 65$	92	69	14	99	25	99

Long Form

ADHD Index subscale	$T \geq 65$	82	87	25	99	41	98

Screening Tools for ADHD (ADHD/Other Condition: CAARS-S

Long Form

ADHD index $T \geq 65$	64	86	19	98	34	96
DSM-IV ADHD Symptom Total $T \geq 65$	64	70	10	97	19	95
Cut score used was 91+ out of maximum of 198	97	83	60	41	57	44
ADHD index $T \geq 65$	65	61	8	97	15	94
DSM-IV ADHD Symptom Total	91	27	6	98	12	96

Screening Tools for ADHD (ADHD/No ADHD): WURS-25

			Estimated rate of ADHD			
			5%		10%	
Cut Score Used	Sen (%)	Spe (%)	PPV (%)	NPV (%)	PPV (%)	NPV (%)
≥ 46	95	75	17	100	30	100
	91	92	37	99	56	99
≥ 46	72	58	8	98	16	95
	37	98	49	97	67	93

Screening Tools for ADHD (ADHD/Other Condition): WURS-25

≥ 46	62	86	19	98	33	95
≥ 36	88	70	61	39	59	42
≥ 46	37	84	11	96	20	92
≥ 46	86	81	19	99	33	98

Screening Tools for ASD: Autism-Spectrum Quotient (AQ) questionnaire

Studied 476 adults, seen consecutively at a national ASD diagnostic referral service for suspected ASD. We tested AQ scores as predictors of ASD diagnosis made by expert clinicians according to International Classification of Diseases (ICD)-10 criteria, informed by the Autism Diagnostic Observation Schedule-Generic (ADOS-G) and Autism Diagnostic Interview-Revised (ADI-R) assessments.

Of the participants, 73% received a clinical diagnosis of ASD. Self-report AQ scores did not significantly predict receipt of a diagnosis. While AQ scores provided high sensitivity of 0.77 **and positive predictive value of 0.76**. the specificity of 0.29 and **negative predictive value of 0.36** were low. Thus, 64% of those who scored below the AQ cut-off were 'false negatives' who did in fact have ASD. Co-morbidity data revealed that generalized anxiety disorder may 'mimic' ASD and inflate AQ scores, leading to false positives.

The AQ's utility for screening referrals was limited in this sample.

Ashwood KL, Gillan N, Horder J, et al. Predicting the diagnosis of autism in adults using the Autism-Spectrum Quotient (AQ) questionnaire. Psychological Medicine. 2016;46(12):2595-2604. doi:10.1017/S0033291716001082

Screening Tools for ASD: Autism-Spectrum Quotient (AQ) questionnaire

ELSEVIER

Psychiatry Research
Volume 312, June 2022, 114580

The utility of the autism-spectrum quotient to screen for autism spectrum disorder in adults with attention deficit/hyperactivity disorder

Doha Bemmouna [a], Sébastien Weibel [b c], Markus Kosel [d], Roland Hasler [d], Luisa Weiner [a c], Nader Perroud [d]

"Our results showed that the AQ is of limited use in this context as its positive predictive value was low (47%). Particularly, the more severe the attentional deficits the more likely individuals with ADHD were to be misclassified as having a co-occurring ASD based on the AQ."

Screening Tools for ASD: RAADS-R

Table 4. Correct classification ability of three self-report questionnaires for ASD in adults.

	Cut-off[a]	Sensitivity (%)[b]	Specificity (%)[b]	PPV (%)[c]	NPV (%)[c]
RAADS-R-NL (n = 210)	85	81	45	74	45
	98	**73**	**58**	**77**	**53**
	115	59	64	76	44
AQ-28 (n = 192)	70	77	41	72	47
	80	**57**	**70**	**79**	**45**
	90	23	88	78	37
AQ-10 (n = 192)	5	79	36	71	47
	7	**62**	**66**	**78**	**47**
	9	27	91	86	39

Sizoo, B. B., Horwitz, E., Teunisse, J., Kan, C., Vissers, C., Forceville, E., Van Voorst, A., & Geurts, H. (2015). Predictive validity of self-report questionnaires in the assessment of autism spectrum disorders in adults. Autism, 19(7), 842-849. https://doi-org.proxy.queensu.ca/10.1177/1362361315589869 (Original work published 2015)

General Limitations of Screening Measures

- Subjective bias of self-report
- High face validity of measures
- Not designed as diagnostic- misunderstanding of screening
- Look for symptoms, not disability
- Do not rule out other possible causes for symptoms experienced or reported

Best Practices Recommendations

- Use screeners for *triage*, not confirmation
- Always combine with observation, interview, and clarification of impact of symptoms/behaviours on ability to access the curriculum
- Communicate clearly about screening results
- Know the tool, population, and context
- Let screening inform, not replace, your judgment

Case Study

- Jordan is a 19-year-old second-year university student who has struggled with attention and academic performance throughout his life. As a result, he was home-schooled from elementary to secondary school.
- He is highly interested in engineering, but has difficulty focusing during lectures, procrastinates on assignments, and misses deadlines. Jordan often reports feeling overwhelmed by the demands of university life. He also describes difficulties in social situations, finding it hard to engage in group work or make connections with peers. He is often described by others as “aloof” and “hard to read,” especially in social contexts.

Case Study

- **Screening Measures Administered:**
  - **CAARS (Conners' Adult ADHD Rating Scales) Self-Report**: Elevated scores for inattention.
  - **ASRS (Adult ADHD Self-Report Scale, Version 1.1)**: Score = 19/24 (suggests high likelihood of ADHD).
  - **AQ:** Elevated score, indicating significant social communication difficulties.

Case Study

- **Initial Interpretation:**
  - **ADHD**: Self-reports and ASRS results align with ADHD symptoms, particularly inattention.
  - **Social Communication Challenges**: Elevated AQ score suggests social difficulties consistent with **ASD traits**, but further investigation is needed.
  - **Academic Issues**: Reported academic challenges may reflect ADHD, but could also point to underlying **learning difficulties** or **anxiety**

If academic impairment as a result of symptoms, refer for PEA + ASD

Screening Evaluation for Neurodevelopmental Disorders (SEND)

- Screening Questionnaire:
  - Screening Evaluation for Neurodevelopmental Disorders (SEND)
  - Starts with a determination of impairment
    - No impairment- may still benefit from assessment but not a RARC/BSWD referral
  - Explores the possible role(s) of neurodevelopmental conditions
  - Helps identify additional underlying or comorbid conditions that may be affecting success

SEND- Part 1

Please complete the following questions as honestly as possible. You may need to consult with family members to accurately respond to some items.

1. I received poor or failing marks in elementary school (e.g., C's, D's, or R's). If yes, please provide report cards. For mature or international students, alternate evidence could include evidence of failed grades, placement in a special education class, and/or reports from family members of historical academic challenges.

Yes **No**

2. I received poor or failing marks (e.g., 60s or below) in secondary school. If yes, please provide report cards. For mature or international students, a secondary school transcript may suffice.

Yes **No**

3. I had an Individual Education Plan (IEP) in elementary and/or secondary school. If yes, please provide at least one IEP from elementary and/or secondary school. For mature or international students, evidence of previous special education services would be sufficient.

Yes **No**

4. I am struggling to meet curriculum expectations in post-secondary (e.g., attaining poor or failing grades, needing to drop classes due to academic difficulty). If yes, please provide a copy of your post-secondary school transcript (can be unofficial).

Yes **No**

5. I am currently registered with Accessibility/Disability Services and have access to formal accommodations in my post-secondary program.

Yes **No**

If yes, please indicate the disability currently being accommodated:

_____

Rationale: Explores historical and current impairment, which provides a basis to evaluate for a possible neurodevelopmental condition.

6. My academic challenges are only evident (circle all that apply):

a. When I am learning in a second language.
b. When I am using alcohol and/or drugs.
c. When I am physically ill (e.g., fibromyalgia, headaches/migraines).
d. When I consistently get less than 7 hours of sleep a night
e. When I am mentally unwell (e.g., depression, anxiety)
f. When perfectionism is interfering with my productivity
g. When I spend more than 2 hours a day on electronic devices instead of doing schoolwork.

If the student responds positively to 1, 2, or 3 <u>and</u> 4 or 5 and says no to all subitems in number 6, move to Part 2. Otherwise, skip to Part 3.

SEND- Part 2

Rationale: If historical and current academic impairment is noted, exploration for the likely type of neurodevelopmental condition may be helpful.

7. My academic impairment is related to academic skill weaknesses (please circle all that apply):

a. Challenges decoding words and/or reading slowly and with effort.
b. Difficulty understanding the meaning of what is read.
c. Difficulty with spelling.
d. Difficulty expressing/organizing ideas in writing.
e. Difficulty with number sense/number facts/or calculations.
f. Difficulty understanding/applying concepts learned in math.

If the student endorses one or more areas of academic difficulty <u>and</u> these challenges logically relate to historical and current areas of impairment, student should be referred to a psychological services provider for an assessment.

8A. **My academic impairment is related to challenges with attention, hyperactivity, and/or impulsivity (please circle all that apply):**

a. I fail to give close attention to details or make careless mistakes in schoolwork, at work, or during other activities (e.g., accidently skip items on tests; commit errors on the job, etc.).
b. I have difficulty sustaining attention during lectures, during conversations, and while completing independent schoolwork.
c. I miss what people say to me because my mind is elsewhere.
d. I find it difficult to follow instructions and complete schoolwork, chores, or duties in the workplace (e.g., start tasks but quickly loses focus and am easily sidetracked).
e. I have difficulty organizing tasks and activities (e.g., difficulty keeping materials and belongings in order; poor time management skills, etc.).
f. I avoid, dislike, or am reluctant to engage in tasks that require sustained mental effort (e.g., completing readings; solving puzzles; preparing papers or reports, etc.).
g. I lose things necessary for tasks or activities (e.g., school materials, pencils, wallet, phone, glasses, etc.).
h. I am distracted by extraneous stimuli or unrelated thoughts.
i. I am forgetful in daily activities (e.g., keeping appointments; meeting up with friends; paying bills, etc.).

8B. **My academic impairment is related to challenges with attention, hyperactivity, and/or impulsivity (please circle all that apply):**

j. I fidget and feel restless (e.g., tap my pen; shake my leg; squirm in my seat).
k. I leave my seat in situations when remaining seated is expected (e.g., cannot remain seated in the classroom or in the workplace).
l. I am "on the go," acting as if "driven by a motor" (e.g., uncomfortable sitting still during a meal or meeting).
m. I talk excessively.
n. I blurt out the answer before a question has been completed (e.g., complete other people's sentences; cannot wait my turn in conversations).
o. I have difficulty waiting for my turn in games or activities (e.g., while waiting in line).
p. I interrupt or intrude on others (e.g., butt into conversations, games, or activities; may take over what others were doing; may start using another person's things without asking).

9A. My academic impairment is related to social/communication challenges and restricted/repetitive patterns of behaviour, interests, or activities (please specify):

a. Deficits in social-emotional reciprocity (e.g., establishing or maintaining a conversation and/or failure to initiate or respond to social interactions with peers or Professors that impair functioning).
b. Deficits in nonverbal communicative behaviours (e.g., abnormalities in eye contact, body language, and/or gesture that impair functioning).
c. Deficits in developing, maintaining, and understanding relationships (e.g., difficulties adjusting behaviour to suite various social contexts to a degree that impairs day-to-day functioning).

9B. My academic impairment is related to social/communication challenges and restricted/repetitive patterns of behaviour, interests, or activities (please specify):

d. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., odd hand mannerisms, echolalia).
e. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, need to take the same route or eat same foods every day).
f. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
g. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

- ***In 8, if the student endorses at least 6 items from a to i <u>and/or</u> at least 6 items from j to p <u>and</u> these challenges logically relate to historical and current areas of impairment, student should be referred to a psychological services or medical provider for an assessment.***

- ***In 9, if the student endorses symptoms a through d <u>and</u> at least two symptoms from d to g <u>and</u> these challenges logically relate to historical and current areas of impairment, student should be referred to a psychological services provider for an assessment.***

SEND- Part 3

Rationale: Regardless of whether the student is currently impaired or is reporting feeling that they are underachieving (without evidence of impairment), exploration of other issues that can "mimic" symptoms of a neurodevelopmental disorder is recommended to link students to appropriate interventions and supports (which can be implemented while waiting for formal assessment- if appropriate).

- **To ensure that they have adequate study skills/work habits:**
  - *Administer Study Skills and Habits Questionnaire (SSHQ)- if impairment noted, refer to Academic Coach/Learning Strategist/Student Academic Success Services.*

- **To investigate for the possible contribution of psychological symptoms:**
  - *Administer APA Cross Cutting Measure (https://www.psychiatry.org/getmedia/e0b4b299-95b3-407b-b8c2-caa871ca218d/APA-DSM5TR-Level1MeasureAdult.pdf)- if challenges identified, refer to Counselling Services.*

- **To investigate for the possible contribution of physical health challenges (poor sleep, erratic eating habits, alcohol/drug use, low iron, thyroid issues, etc.):**
  - *Ask student if they are concerned about their sleep, eating habits, or general health. If yes, refer to physician.*

- **To investigate for the possible contribution of social media/technology/video game addiction:**
  - *Administer measure of internet addiction (https://psychology-tools.com/test/internet-addiction-assessment). If challenges are identified, refer the student to counselling services and an Academic Coach/Learning Strategist.*

What Do I Do in the Meantime?

General guidelines for reasonable INTERIM accommodations

1. If you suspect ADHD. There is no research support for providing extra test-taking time (see Jansen et al., 2018; Miller et al., 2015; Pritchard et al., 2016).

- Referral to learning strategies/academic skills help
- Peer mentors
- Stop the clock breaks (up to 15 min/hour for them to get up, stretch, and refocus)
- Quiet room for tests (but this may make things worse for some students- some may find it of benefit, others not and we are not yet able to predict who will benefit)
- Depending on findings from the screeners, refer out as appropriate for other co-morbid problems, plus refer for diagnostic assessment.

2. If suspect Reading Disability. What are reasonable temporary accommodations?

- Start conservatively (15 min/hour only for tests with a large reading component)
- Depending on other results from above, refer out as appropriate for other problems, plus refer for diagnostic assessment
- Refer for training in use of Read and Write Gold.

3. If suspect Math Disability. What are reasonable temporary accommodations?

- Start conservatively (15 min/hour only for math-based tests)
- Refer to peer tutoring/academic skills centre
- Plus refer for diagnostic assessment

4. If suspect Writing Disability. What are reasonable temporary accommodations?

- Extra time only for tests/activities that require essay writing (not for things like multiple choice)
- Refer for training in use of Read and Write Gold
- Offer use of technology in tests (but this may cause more problems if student is not familiar with using this technology).

5. If suspect Mental Health difficulty. What are reasonable temporary accommodations?

- There is NO research support for provision of extra test-taking time (see Harrison et al., 2021)

Offered accommodations could include:

- quiet room for writing tests
- stop the clock breaks (up to 15 min/hour for them to get up, stretch, and refocus)
- referral to counselling
- possibly to physician for medication consultation
- ability to rewrite test if student has panic attack during test (and if stop-the-clock break does not help them reduce the panic at the time).
- General rule around accommodations, temporary or otherwise.

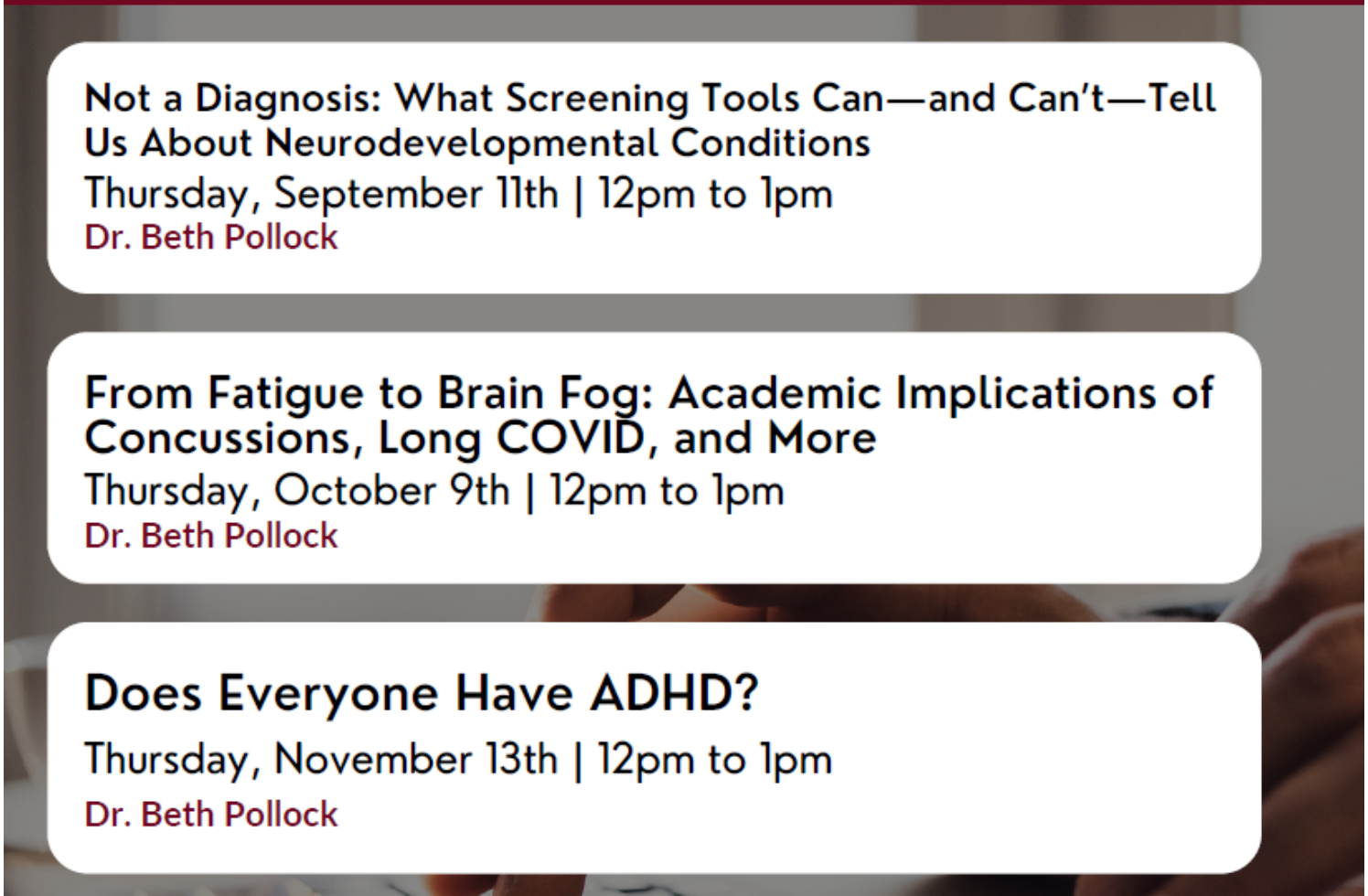
Questions?

Regional Assessment Resource Centre:

Lunch and Learn Series

Fall 2025

Free to join. No registration required.



Not a Diagnosis: What Screening Tools Can—and Can't—Tell Us About Neurodevelopmental Conditions

Thursday, September 11th | 12pm to 1pm

Dr. Beth Pollock

From Fatigue to Brain Fog: Academic Implications of Concussions, Long COVID, and More

Thursday, October 9th | 12pm to 1pm

Dr. Beth Pollock

Does Everyone Have ADHD?

Thursday, November 13th | 12pm to 1pm

Dr. Beth Pollock

Thank You!

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