# The Use of Artificial Intelligence (AI) to Fabricate Medical Documentation: What Disability Accommodations Professionals Need to Know

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**Introduction**

Artificial intelligence (AI) has the potential to transform the testing industry by offering groundbreaking new possibilities in test construction, item creation, test proctoring, operational efficiency, and more.

However, as we continue to see the rapid integration of AI technology across the industry, it is important to note that this evolution also poses risks. Newfound risks include novel approaches to cheating and item harvesting, the use of AI-generated (but inaccurate or inappropriate) test items, and profiling risks in AI-proctored exams.

Organizations that review accommodations requests are now seeing an uptick in AI-generated documentation used to support requests for disability-related accommodations. Testing organizations whose staff review accommodation requests only see the paperwork—unlike the university setting, testing entities do not meet face-to-face with applicants. Thus, testing organizations rely on candidates and their advocates to provide authentic, professional documentation. The emergence of generative AI increases the ease and efficiency of fabricating convincing medical reports, psychological assessments and other professional letters – complete with logos, signatures and comprehensive "test results." To many, these documents can be nearly indistinguishable from legitimate documents, increasing the challenge in detecting fraud.

This is a broad and deep topic. This article will not delve into too many of the "technicalities", but instead, keep the focus on a plain-English discussion of the issues that are most relevant to reviewers of requests for disability-related accommodations, especially in the context of high-stakes testing. The following paper was authored by a working group of certification, legal, and accessibility experts during recent discussions. This working group raised ethical, legal and operational questions, which are addressed below.

**What is AI?**

Defining Artificial Intelligence from nasa.gov:

> Artificial intelligence refers to computer systems that can perform complex tasks normally done by human-reasoning. AI tools sometimes use machine learning, which uses data and algorithms to train computers to make classifications, generate predictions, or uncover similarities or trends across large datasets.
>
> There is no single, simple definition of artificial intelligence because AI tools are capable of a wide range of tasks and outputs, but NASA follows the definition of AI found within EO 13960, which references Section 238(g) of the National Defense Authorization Act of 2019.

- Any artificial system that performs tasks under varying and unpredictable circumstances without significant human oversight, or that can learn from experience and improve performance when exposed to data sets.
- An artificial system developed in computer software, physical hardware, or other context that solves tasks requiring human-like perception, cognition, planning, learning, communication, or physical action.
- An artificial system designed to think or act like a human, including cognitive architectures and neural networks.
- A set of techniques, including machine learning that is designed to approximate a cognitive task.
- An artificial system designed to act rationally, including an intelligent software agent or embodied robot that achieves goals using perception, planning, reasoning, learning, communicating, decision-making, and acting.

**How can it be used to create fake medical documentation?**

AI technologies (such as ChatGPT) can be used to create fake but official-looking documents. While for many years testing organizations have occasionally found evidence of fake or tampered-with medical records, AI's increasingly advanced capability to produce authentic-looking documents has opened the doors to fraud. AI tools can fabricate realistic-looking insurance claims, university transcripts, identification papers, medical and psychological reports, and other sensitive documents with minimal time, effort, or expertise required from the user. Unlike traditional methods of document fraud, which typically involve *altering existing documents*, AI allows fraudsters to create entirely synthetic documents with a few simple keystrokes. [See **Appendix A** for an example of a psychological report created with ChatGPT that is entirely fictitious.]

AI has already been implicated in several scandals involving creation of fraudulent but authentic-looking scientific medical articles (e.g. Májovský, 2023). Healthcare organizations and insurance companies face an escalating challenge as AI tools produce increasingly realistic medical documentation ranging from doctor's notes to complete patient records. For example, recent UAE cases resulted in four hospital closures due to AI-generated sick leave fraud (anon., MSN 2025). Scammers have created entirely fake medical websites (anon., MDLinx Staff, 2025), fake medical doctors (Clark, 2025; Stewart, 2025), fabricated citations (Diaz, 2025), and medical credentials that appear legitimate (Hogan, 2025).

**Why is AI-generated document fraud on the rise**?

Industries like insurance and banking see AI fraud used primarily for the purpose of financial gain (Ryan, 2024). In the world of high-stakes testing and at highly competitive universities, *everyone wants a competitive advantage*. Students at highly competitive colleges and graduate

schools may have spent hundreds of thousands of dollars and invested many years into their education, so the pressure to perform well is huge. With most US institutions following the "medical model" of disability (Disability Nottinghamshire, 2025) and relying on medical evidence to support accommodations requests, all one needs to do to get extra time and other accommodations is to produce a medical note or report that suggests a particular diagnosis. In our experience, having a medical diagnosis is sufficient to get approved for disability accommodations, even though in many cases, having a valid medical diagnosis does not automatically mean that a person is *disabled* under applicable law (anon., n.d., ssa.gov). For example, for only $189, one prominent online ADHD diagnostic company (ADHDOnline.com) will provide a "report" that, in our experience, is sufficient to garner accommodations for even the most competitive high-stakes testing programs and universities. [See **Appendix B** for a sample list of online ADHD providers.]

There has been an astronomic rise in reported disabilities at the most highly competitive institutions recently. A recent study by the American Bar Association found that an average of 20% of law school students claim to be disabled, a more than four-fold increase from just a few years ago (Davis, 2025). Likewise, recent studies have found that disability accommodation use has soared at the many elite US universities, with some top colleges reporting that nearly 40% of their students are receiving disability accommodations (Horowitch, 2025).

A *New York Times* investigation found a strong correlation between families of wealth and incidence of accommodations on college entrance exams (Goldstein & Patel, 2019). Paradoxically but perhaps not surprisingly, those who have access to better financial resources seem to be "disabled" at a much higher rate. Curiously, we have seen no research that this disability "epidemic" has migrated to community colleges, less competitive vocational fields, or schools in less economically-advantaged areas.

**How do we identify fake documentation?**

When reviewing supporting documentation related to accommodations requests, what are some of the document features that might give us an indication that the document was fabricated using AI?

Our group has compiled a list of document features to check (see **Appendix C**). Of course, these are manual, labor-intensive document investigations that, frankly, many organizations do not have the resources to conduct. However, these tips might be useful when a particular document raises suspicion and needs further investigation.

Perhaps an AI tool could be used to check the authenticity of disability-related supporting documentation? Our group has noted that AI tools themselves could potentially be used to determine the likelihood that a particular medical or other document has been fabricated using AI. However, at this time, many of our testing organizations have concluded that the potential risks to privacy (including potential violations of medical privacy laws) and security (including having sensitive medical documents being stored in a cloud) outweigh any potential benefits of

using AI for the purpose of AI detection. It is our hope that in the future, technology could be developed to be able to more efficiently and accurately check the veracity of disability-related supporting documentation.

**Was the medical or psychological evaluation done using an AI "evaluator"? Is that acceptable?**

As noted above, many organizations (particularly in the US) continue to adhere to the "medical model" of disability, and thus, require diagnostic medical evidence to support a person's disability accommodation request. Given the aforementioned concerns about the ease at which medical records can be fabricated or falsified using AI, and the surge in the number of online assessment companies (especially in the ADHD space; See **Appendix B** for references), it is important to clearly specify what types of medical documentation will be acceptable, and to what extent AI-generated medical reports will be permitted. Thus, we have suggested best practice guidelines, below. These could be incorporated into an organization's *Documentation Guidelines*, to clearly delineate what types of clinical evaluations and reports are acceptable.

- The evaluation was conducted by a licensed health care provider in an appropriate field (not an AI evaluator).
- The clinician has met with the client, either virtually or in-person (not just an AI tool aggregating scores on self-report symptom checklists).
- Information contained in the report is *individualized* to the client (not just boilerplate symptom lists or diagnostic criteria).
- The evaluator reviews both objective and subjective information (not only self-report checklists).
- Recommendations are *personalized* to the client (not just boilerplate), based on their unique challenges and their anticipated functional impairments in the setting of interest.

**How should we message this concern to students and test-takers?**

An initial investigation of approximately 40 credentialing agencies within the United States revealed that none have a specific publicly-visible policy that addresses the misuse of AI in the accommodations process; specifically, prohibiting the use of AI to generate fraudulent documentation. Fabricated documents using AI tools might include academic records, letters from healthcare providers, psychological assessments, psychiatric records, university transcripts, evidence of an internship or training hours, and medical test results.

Depending on the jurisdiction, the submission of fraudulent medical documentation may constitute a criminal offense under the law. Organizations must weigh the legal risks of both acting on and ignoring suspected fraud. Accrediting bodies such as the National Commission for Certifying Organizations (NCCA) require meaningful disciplinary standards, adding another layer of responsibility for certification programs.

Most testing agencies we surveyed do have a public-facing policy concerning misrepresentation or fraud that prohibits the submission of false documents. Many high-stakes testing bodies have codes of ethics, testing rules, and candidate agreements that can be powerful tools to respond to and address fraudulent documentation of any sort, including supporting documentation for exam accommodations. Violations of these rules and codes can often result in the denial of a credential or other disciplinary measures, providing an important deterrence mechanism to prevent fraud in the first place.

Thus, the question: Should testing agencies specifically address the potential use of AI in generating false documents, or are current policies concerning fraud enough of a deterrent? We recommend that *the misuse of AI should be addressed directly* rather than relying on generic fraud policies to deter the submission of falsified AI-generated documentation. We suggest that a public-facing policy that indicates that a program is taking active measures to address this type of fraud and is willing to discipline those that commit fraud may be a strong first step in its deterrence. A sample policy is found in **Appendix D**.

**Potential Mitigation Strategies**

Our panel identified several strategies that organizations should consider for mitigating the potential for abuse of AI in the accommodations process:

- **Consider training documentation reviewers.** Professionals who routinely review disability accommodation requests and supporting documentation may not be aware of the potential for fraudulent, AI-generated documentation that appears authentic.

- **Ask students and candidates to verify the authenticity of documentation:** Shift the burden of proof from organizations to candidates when documentation is unverifiable. If supporting documentation is questionable or cannot be verified, require the individual to prove the authenticity of the documentation provided.

- **Review and update policies:** Review existing organizational codes of ethics or conduct, testing rules, and candidate agreements to ensure inclusion of a policy regarding documentation authenticity. Where appropriate, include explicit prohibitions against AI fabricated documentation such as suggested in Appendix C.

- **Require handwritten elements**: In some cases, inclusion of a handwritten statement or handwritten signature on supporting documentation may reduce AI forgery.

- **Emphasize the importance of individualized, personalized documentation**. AI-generated medical documentation is typically overly generalized and generic. In contrast, helpful documentation should come from *a professional who knows the applicant well* and who can discuss their own direct observations of the person's actual functional limitations (not just symptoms of a diagnosis), common barriers to access

that the person faces, and other information that makes it clear that the professional has directly interacted with the person with a disability.

- **Determine if diagnostic medical evidence is really crucial to the organization's accommodations process**. Consider moving towards a "social model of disability" framework, which is more commonly the approach used in Europe, that de-emphasizes the diagnosis = disability misnomer. The application of the social model emphasizes the functional ***impact*** of a person's condition, rather than the underlying medical *cause* (*Opinion - Supporting Students with Disabilities: A Call for Change in Eligibility Criteria*, 2024.). Operationally, this approach allows for inclusion of documentation from *professionals who know the applicant well* and who can provide more personalized, individualized information than merely a diagnostic statement. This might include documentation from employers, faculty advisors or mentors, disability-service staff at universities, therapists, or guidance counsellors.

**Conclusion**

While not new to the high-stakes testing industry, AI has made it simple, easy, free, and efficient to fabricate medical documentation that appears authentic. In our experience, there has been a dramatic rise in accommodation requests that include a report of an online diagnostic evaluation, many of which appear to rely on AI to simply aggregate the results of symptom checklists. This does not provide testing organizations with individualized information unique to the applicant, limiting those organizations' ability to make personalized decisions about the need for test accommodations. As AI technology evolves, so must the policies, procedures, and practices of organizations that review accommodations requests in order to safeguard standards and ensure fairness to all.

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**Appendix A**: Fabricated, AI-generated report that is entirely fictitious.

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# Psychological Evaluation Report

*Sample clinical-style report for demonstration/formatting purposes.*

## Identifying Information

**Client:** Frank Frankenstein
**Date of Birth:** 01/01/1898 **Age:** 127 **Gender:** Male
**Evaluation Date:** August 18, 2025
**Evaluator:** Dr. Sally Snodgrass, M.D.

## Reason for Referral

Mr. Frank Frankenstein presented for diagnostic clarification regarding chronic attentional difficulties, disorganization, and impaired task follow-through affecting daily functioning. The purpose of this evaluation was to assess symptom pattern, developmental course, functional impairment, and differential diagnoses consistent with DSM-5-TR criteria for ADHD.

## Sources of Information

• Clinical diagnostic interview (self-report)
• Behavioral observations during appointment
• Adult ADHD Self-Report Scale (ASRS v1.1) – self-report screening
• Collateral report (family member) – verbal summary

## Presenting Concerns and Symptom Summary

Reported concerns included distractibility, difficulty sustaining attention on reading and meetings, frequent loss of items, forgetting appointments, procrastination, and difficulty completing multistep tasks. He described needing external structure (lists/reminders) yet still missing deadlines. Symptoms were reported as longstanding with functional impact across academic and occupational contexts.

## Developmental Course and Onset

Mr. Frankenstein reported that attentional and organizational difficulties were present since childhood, including teacher feedback about incomplete assignments and daydreaming, and persistent difficulty with sustained mental effort. Collateral information supported a chronic course rather than an episodic onset.

## Behavioral Observations and Mental Status

Mr. Frankenstein was alert, oriented, and cooperative. He displayed frequent fidgeting and occasional topic shifts, requiring redirection. Speech was fluent and coherent. Mood was reported as euthymic; affect was appropriate. Thought process was linear. No evidence of psychosis or acute safety concerns was observed within the limits of this encounter.

## Assessment Results (Selected)

**ASRS v1.1 (Adult ADHD Self-Report Scale):** Self-report responses fell in a range consistent with clinically significant ADHD symptoms. The ASRS is a screening tool and does not confirm diagnosis on its own; results were interpreted alongside interview history and impairment.

**Functional Impairment:** Reported impairment included missed deadlines, inconsistent follow-through, inefficiencies at work, and reliance on compensatory strategies that remained insufficient.

## Diagnostic Formulation

The clinical picture is most consistent with Attention-Deficit/Hyperactivity Disorder (ADHD), Predominantly Inattentive Presentation. Symptoms were reported as persistent, present in more than one setting, and associated with clinically significant impairment. Developmental history supports onset in childhood. Alternative explanations (e.g., mood disorder, anxiety disorder, sleep disturbance, substance effects) were considered; available information did not indicate that these better accounted for the symptom pattern.

## DSM-5-TR Criteria Summary (ADHD, Predominantly Inattentive Presentation)

**Inattention symptoms (examples endorsed):** difficulty sustaining attention; does not seem to listen; fails to finish tasks; difficulty organizing; avoids sustained effort; loses things; easily distracted; forgetful.
**Hyperactivity/impulsivity:** limited endorsement relative to inattentive symptoms; occasional fidgeting/interruptions reported.
**Additional criteria:** symptoms present since childhood; symptoms present across settings; clear evidence of impairment; not better explained by another disorder (based on available data).

## Differential Diagnosis Considerations

• **Anxiety disorders:** can mimic inattention via worry/rumination; reported symptom pattern was longstanding and not exclusively anxiety-linked.
• **Depressive disorders:** can reduce concentration; no primary depressive syndrome reported in the history provided.
• **Sleep disorders:** insufficient sleep can impair attention; sleep hygiene assessment and medical screening may be considered if clinically indicated.
• **Substance/medication effects:** no substance pattern reported that better explains symptoms.

## Diagnostic Impression

**F90.0 — Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation, Moderate**

## Recommendations

1. **Medication consultation/management:** Discuss risks/benefits of stimulant vs. non-stimulant options and monitor response and side effects.
2. **Skills-based psychotherapy:** CBT for ADHD targeting planning, prioritization, procrastination, and emotional regulation.
3. **Executive-function supports:** Externalize memory with calendars, alarms, and checklists; break tasks into timed steps; use “body-doubling” or coworking to initiate tasks.
4. **Workplace accommodations (as applicable):** written instructions, clear deadlines, reduced-distraction workspace, scheduled check-ins, and chunked deliverables.
5. **Health factors:** consistent sleep schedule, regular aerobic exercise, and limiting alcohol/caffeine close to bedtime.
6. **Follow-up:** Reassessment of symptom control and functional outcomes after treatment initiation (e.g., 8–12 weeks) and periodically thereafter.

Note: This document is a **sample** report generated for formatting and example purposes and is not a substitute for a real-world clinical evaluation.

*Sally Snodgrass*

**Appendix B**

Sample list of online ADHD diagnostic providers

- https://beyondadhd.ca
- https://adhdonline.com/
- https://www.clinical-partners.co.uk/for-adults/adult-adhd-add/test-for-adhd
- https://mindmetrix.com/individuals
- https://mentavi.com/
- https://rittenhousepa.com/services/adhd-diagnosis-and-accommodations/
- https://www.talkwithfrida.com/

**Appendix C**

Tips for identifying potentially AI-generated documentation:

PDF Container Clues

- Producer/Creator name (medical system vs. generic tool)
- Page size (Letter vs. A4)
- Creation date vs. modification date alignment
- Page count matches stated total

Visual/Structural Clues

- Font consistency (size, baseline, margins)
- Logo/letterhead clarity (vector vs. pixelated); logo consistency between multiple documents
- Signature/stamp quality (natural vs. pasted/haloed)
- Redaction integrity (true blackout vs. overlay)
- AI placeholders (e.g. [Insert name here])

Linguistic/Medical Plausibility

- Proper credential/title formatting (MD, DO, PhD)
- Specific vs. generic diagnosis language (ICD-10, CPT codes)
- Natural clinical phrasing vs. excessive use of boilerplate
- Date and phone number formats consistent with locale
- Recommended accommodation does not align with the diagnosis/functional impairment (a person diagnosed with ADHD provides a report that recommends screen magnification software)
- Certain terms/phrases are overly repeated

Consistency Checks

- Header/footer dates match metadata
- Clinic contact info matches real provider
- Document timeline consistency with the subject history
- Previous documents are different when resubmitted

**Appendix D**

Sample policy regarding the use of AI to fabricate or falsify documentation:

*The submission of fraudulent, fabricated or altered documentation, including documentation generated or modified by artificial intelligence (AI), to intentionally mislead [Organization's Name] for any purpose is strictly prohibited. Any such conduct will be subject to disciplinary action in accordance with [Organization's Name] policy on misconduct, and potentially, to actions under civil and criminal law. [Organization's Name] reserves the right to investigate the authenticity of any supporting documentation that is provided for the purpose of obtaining testing accommodations. By requesting accommodations for the [Name of Examination], you authorize [Organization's Name] to conduct such an investigation, which may include contacting the author(s) of any documents submitted to verify their authenticity.*

*Prohibited candidate actions include but are not limited to: (1) Submitting fabricated or altered documentation of any kind, including documentation that has been altered using AI technology, or (2) Using AI tools to create or modify supporting documentation such as letters from qualified professionals, medical records, clinical assessments, evaluation reports, academic records, or any other documents that misrepresent an individual's disability status or accommodation needs.*