Documentation of Disability Form

Disability Support Services @ Stony Brook University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. Current and comprehensive disability documentation from a qualified provider (unrelated to the student) who is treating, or assessed, the specific disability for which accommodations are being requested is required to assist with the provision of appropriate, reasonable accommodations and auxiliary aids. Additional documentation may be required.

Form must be completed by provider

All items are required. Please print or type:

Today's Date:_____

Student's Name:_____ DOB: _____

Provider's Name:_____ License/Credential_____

Address:_____

Phone:_____ Fax:_____

Date of Initial Diagnosis: _____ Date of most recent evaluation: _____

Diagnosis: _____

Secondary/Tertiary Diagnoses: _____

Functional limitation(s) caused by this (these) condition(s): _____

_____

_____

Current status of condition(s) (e.g. Active, Progressing, Controlled, In Remission): ____

_____

Please list any medications related to the condition(s) that the student is currently taking, including dosage and frequency, if pertinent. Please include any disabling side-effects the student is experiencing: _____

_____

_____

Recommended accommodation(s) or auxiliary aids (please explain relationship of accommodation to functional limitation): _____

_____

_____

_____

Anticipated duration of accommodation(s): _____

_____

For students with the following disabilities, please attach the requested additional information:

Cognitive Disabilities: Most recent testing results (should include tests of aptitude and achievement-full scale, not abbreviated) **scores and the clinical narrative**.

ADHD/ADD: History of ADHD/ADD, means of diagnosis, and evaluation of current impact.

Psychological, Psychiatric or Emotional Disabilities: Presenting symptoms and treatment.

Deaf/Hearing Impairment: Audiogram and performance section of a psychological evaluation if available

Blind/Visually Impairment: Visual acuity and, if applicable, CBVH certification number.

Provider Signature: _____

Please return to:

Disability Support Services@ Stony Brook
128 ECC Building
Stony Brook NY 11794-2662

I, _____, authorize the above provider to release to the Office of Disability Services the above requested information for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Stony Brook University .

Signature of student:_____ Date: _____

** If signed by person other than student, state relationship and authority to do so.

Relationship: _____ Legal authority: _____

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