Student Accessibility
Support Services
www.stonybrook.edu/sasc

128 ECC Stony Brook NY 11794-2662
(631) 632-6748 Fax (631) 632-6747
SASC@stonybrook.edu

Documentation of Disability Form

Student’s Name: ___________________________ Student DOB: ___________________________
SBID#: ______________________ Telephone: ___________________________

Stony Brook University complies with federal and state disability laws that prohibit discrimination and require that Universities ensure equal access for qualified persons with disabilities to educational programs, services, and activities. Please complete the form below to assist D.S.S. in determining appropriate and reasonable disability accommodations. Additional documentation may be required.

To be completed by the student’s treating provider, who is NOT a family member.
Please answer all questions that apply to the particular disability. Please print legibly.

Complete Diagnosis: ___________________________
______________________________
______________________________

Date of Diagnosis: ___________________________

Date of last visit for this condition: ___________________________

Procedures/assessments used to diagnose this student’s condition (ATTACH COPIES of assessment results used in making/confirming diagnosis):

______________________________
______________________________

Severity of the condition: Temporary Mild Moderate Severe

Student is compliant with medical treatment for this condition: Rarely Sometimes Often Unknown

Does this student take prescription medication for this condition? Yes No If yes, which medications? Please note any side effects:

______________________________
______________________________
______________________________________________
Epi-Pen? Yes No

Describe how this condition substantially limits a major life activity. (“basic activities that the average person in the general population can perform with little or no difficulty.”)

______________________________
______________________________

With what frequency does this student experience the limitation(s)? Rarely Occasionally Frequently

How will the limitation(s) interfere with this student’s ability to participate in student life (e.g., academics, recreation, etc.)?

______________________________
______________________________

Describe any substantial equipment prescribed for this student’s home or school environment:

______________________________
______________________________

Recommended accommodation (must be clearly linked to functional limitations):

______________________________
______________________________

List all hospitalizations related to the disability:

______________________________
______________________________

Provider’s Signature: ___________________________

Affix business card or apply business stamp within this box

Physician’s Name: ___________________________
Address: ___________________________
________________________________________
License/Cert. #: ___________________________ State: __________
Specialty: ___________________________
Phone: __________________ Fax: __________________