Verification of Disability Form

Dear Health Care Professional:

The Office of Disability Services (ODS) at SUNY Orange provides services to students with documented disabilities to ensure equal access to educational programs and activities. To determine eligibility, this office requires current and comprehensive documentation of the disorder or disability from a diagnosing physician, psychiatrist, or fully licensed psychologist. Information shared with this office is confidential. All records are housed in the ODS at SUNY Orange and are not part of the students academic record. To ensure our office provides appropriate support for the student, please complete this form.

Part A: Student Information
Please sign and date below and fill in all other areas using Print or Type.

Student Name (Print): __________________________________________ DOB: ___________________
Address ______________________________________________________________________________
City: ________________________________________ State: ________________ Zip: _______________
Phone Number: _______________________________ Cell Phone #: _____________________________
Email address: _________________________________________________________________________
Student Signature: ____________ Date: ___________________

Part B: Licensed Healthcare Provider Information
Please sign and date below and fill in all other areas using Print or Type

Provider Name (Print): ____________________________________ Title: _____________________________
License or Certification Number: __________________________________________________________
Address: ______________________________________________________________________________
City:  ______________________________________ State: _________________ Zip: _______________
Phone Number: ______________________________ Fax Number: _____________________________
Email address: _________________________________________________________________________
Provider Signature: ___________________________ Date: ________________________

To Be Completed by a Licensed Health Care Provider

➢ Please complete all applicable and pertinent information in both Sections I and II in order for the above named student to receive appropriate academic accommodations in a classroom or testing environment.
Section I

Diagnostic Information:
(Please print or type legibly)

1. DSM-IV Diagnosis

   Axis I: ________________________________________________________________
   Axis II: ______________________________________________________________
   Axis III: ______________________________________________________________
   Axis IV: ______________________________________________________________
   Axis V (GAF Score): ____________________________________________________

2. In addition to DSM-IV criteria, how did you arrive at your diagnosis?
   □ Structured or unstructured interviews with student
   □ Interviews with other persons
   □ Behavioral observations
   □ Development history
   □ Educational history
   □ Medical history
   □ Neuro-psychological testing – Date(s) of testing ____________________________
   □ Psycho-educational testing – Date(s) of testing ____________________________
   □ Standardized or non-standardized rating scales ____________________________
   □ Other (please specify) _________________________________________________

3. What is the severity of the disorder? □ Mild □ Moderate □ Severe
   Please describe the severity checked above:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

4. Please describe the patient’s symptoms relating to this diagnosis
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5. What specific symptoms does the patient have that might affect the student’s academic
   performance at SUNY Orange.
   _______________________________________________________________________
   _______________________________________________________________________
6. Is this student currently receiving therapy or counseling?
   ☐ Yes ☐ No ☐ Not sure ☐ Other: please explain
   ________________________________________________________________

7. What medications is the patient currently taking? How effective is the medication? How might side effects, if any, affect the student’s academic performance?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

8. Current compliance with medication plan. ☐ Yes ☐ No ☐ Other
   ________________________________________________________________

9. Please indicate accommodations that may be helpful for the student. Each recommendation should include an explanation of its relevance to the diagnosis or area of functional limitation. (Final determination of appropriate accommodations will be determined by our office in accordance with the mandate of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.)
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Section II

Diagnostic Information
(Please print or type legibly)
   1. What is the diagnosis, date of diagnosis and last contact with the patient?
      ________________________________________________________________
      ________________________________________________________________
      ________________________________________________________________

   2. Is the student/patient currently under your care? ☐ Yes ☐ No

   3. List current medication(s), impact, and adverse side effects.
      ________________________________________________________________
      ________________________________________________________________
      ________________________________________________________________

________________________________________________

________________________________________________

________________________________________________
4. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

______________________________________________________________________________________________________________________________________________________________________________________

5. Major Life Activities Assessment

Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>1 - Negligible</th>
<th>2 - Moderate</th>
<th>3 - Substantial</th>
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<tbody>
<tr>
<td>Talking</td>
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<tr>
<td>Hearing</td>
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<td>Performing Manual Tasks</td>
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<td>Sleeping</td>
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<td>Learning</td>
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<td>Concentrating</td>
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<td>Memorizing</td>
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<td>Interacting with Others</td>
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<td>Other:</td>
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<td>Other:</td>
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</tbody>
</table>

6. Describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

______________________________________________________________________________________________________________________________________________________________________________________

7. What is the expected duration of this disability?
8. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_______________________________________________________________________________

9. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/adjustments/services are warranted based upon the student’s functional limitations. Indicate why the accommodations are necessary.

_______________________________________________________________________________

_______________________________________________________________________________

10. Please include any additional information you believe may be helpful, if applicable.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please return completed forms to one of our offices listed below along with any questions or concerns you may have.

**Middletown Campus**
Melanie Bukovsky, Disabilities Specialist
Office of Disabilities Services
SUNY Orange
115 South Street
Middletown, NY 10940
845 341-4077
Fax: 845 341-4360
Email: melanie.bukovsky@sunyorange.edu

**Newburgh Campus**
Jennifer Clayton, Disabilities Specialist
Office of Disabilities Services
SUNY Orange
Kaplan Hall, Room 128
Newburgh, NY 12550
845 341-9034
Fax: 845 220-4063
Email: Jennifer.clayton@sunyorange.edu