SUNY ORANGE

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115 SOUTH STREET, MIDDLETOWN, NEW YORK 10940 (845)344-6222 ONE WASHINGTON CENTER, NEWBURGH, N EW YORK 12550 (845)562-2454

Verification of Disability Form

Dear Health Care Professional:

The Office of Accessibility Services (OAS) 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 OAS at SUNY Orange and are not part of the student's 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 Typ.

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 DNo □ 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? DYes DNo

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 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.

Life Activity	1 - Negligible	2 - Moderate	3 - Substantial
Talking	□	□	□
Hearing	□	□	□

Breathing	□	□	□
Standing	□	□	□
Sitting	□	□	□
Walking	□	□	□
Seeing	□	□	□
Writing	□	□	□
Performing Manual Tasks	□	□	□
Sleeping	□	□	□
Learning	□	□	□
Reading	□	□	□
Thinking	□	□	□
Concentrating	□	□	□
Memorizing	□	□	□
Interacting with Others	□	□	□
Other:	□	□	□
Other:	□	□	□

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.

SUNY Orange County Community College
Office of Accessibility Services
115 South Street
Middletown, NY 10940
845 341-4642
Email:
accessibilityservices@sunyorange.edu