SUNY MORRISVILLE
EST. 1908

Office of Accessibility Services

Telephone: (315) 684.6349 asctesting@morrisville.edu

Request for Information RE: Medical Provider Form

(The heath care provider need not use this specific form, but all the information requested here is necessary for the institution to have in order to consider the request for an accommodation. This form is provided as a convenience.)

Student's Name:_________________DOB:______________Expected Year of SUNY Morrisville Graduation_______

Home Phone: __________________Cell Phone:____________________Email_____________________________
Address:____

By signing I give permission for the ASC to contact the medical provider below with any questions related to this document and request.

Student Signature (must be a wet signature):____

Please note: The above named student has indicated that you are their treating provider, who has knowledge of a disability which substantially limits a major life activity. Generally, we prefer documentation from providers in the State of NY or the student's home state who have personal knowledge of the student, consistent with their professional obligations. We ask that the practitioner who completes this form NOT be a family member, or relative of the student. The provider must also be licensed / certified to practice.

So that we may better evaluate the request for this accommodation, please answer the following questions:

Information about the Student's Disability

Federal law identifies a person with a Disability as someone who has a physical or mental impairment that substantially limits one or more major life activities. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation).

What is the diagnosed condition (use table below)?:

Diagnosis	Diagnostic Code From:	Does this disability or impairment substantially limit a major life activity?	Please rate the severity of the disability or impairment:	Please describe this disability or impairment:
	○ DSM-5 ○ DSM- 5 TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive
	○ DSM-5 ○ DSM- 5 TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive
	○ DSM-5 ○ DSM- 5 TR ○ ICD-9 ○ ICD-10	○ Yes ○ No ○ When active	○ Mild ○ Moderate ○ Severe	○ Stable ○ Variable ○ Progressive

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When did you first meet with the student regarding this diagnosis, and in what context (was it face to face or a virtual interaction)?_____

How was the diagnosis made? (For example, what form of assessment did you rely upon?):_____

When did you last interact with the student regarding this diagnosis?_____

Will there be any follow up appointments with the student? If yes, when is the next appointment scheduled?

_____

Does the student require ongoing treatment or medication?_____

Are you prescribing the medication / administering treatment?_____

What is the nature of the student's impairment (i.e., how is the student substantially limited?) You may use additional sheets or letterhead to answer if necessary.

_____
_____
_____

How will the limitations of the disability / condition affect the student's ability to function?

_____
_____
_____

What conditions will cause the disability to manifest?

_____
_____
_____

Has the student received accommodations in the past (high school, vocational education, college)?

_____

Please make specific recommendations for accommodations this student will require to have equal, appropriate and reasonable access to services and programs.

_____
_____
_____

Information of Certifying Professional:

Name:_____

Professional Title: _____Highest Degree_____

Phone:_____Email:_____

Address_____

License/certification, number and state:_____

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Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The named student has signed a release of information indicating written permission to share additional information with us in support of the request.

Please return this completed form to: **ASCTesting@morrisville.edu** or Accessibility Services Center, Butcher Library, Rm 208, SUNY Morrisville, 80 Eaton Street, PO Box 901, Morrisville, NY, 13408