New Paltz
STATE UNIVERSITY OF NEW YORK
Disability Resource Center

Disability Verification Form

For Academic Accommodations ONLY. If you need other accommodations, please contact the Disability Resource Center via email at drc@newpaltz.edu

To ensure the provision of appropriate academic accommodations for students with Chronic Health-Related Illness, Attention Deficit Disorders and Psychological Disabilities at SUNY New Paltz, documentation must be provided by a qualified medical practitioner with experience and expertise in the area for which accommodations are being requested. The diagnostician must be an impartial individual who is not a family member of the student. Documentation must be current and provide comprehensive information regarding the student's disability and need for accommodations being recommended.

Student Section:

The area directly below should be completed by the student (Please TYPE clearly in the sections below - this is a fillable .pdf form) and then send it electronically to the medical practitioner for completion:

Legal Last Name: ____________________ **Legal First Name:** __________________

Preferred First Name: _____________________ **Pronouns:** ____________________

New Paltz Email Address: ____

Student ID/Banner Number (N0….): ____

The request is being made for: [Semester - Fall ____ or Spring _____] and Year ________

Medical Practitioner Section:

The sections below should be completed by the medical practitioner (Please TYPE clearly in the sections below - this is a fillable .pdf form) for the student listed above who has requested disability related services and accommodations from the Disability Resource Center at SUNY New Paltz.

Diagnosis/DSM 5 Diagnosis:

Date of Diagnosis: ___________ Date of your last contact with the student: _______________

How frequent are/were your treatment or therapy sessions with this student?

Weekly: _____ Bi-Weekly: _____ Monthly: ____ Yearly: ____ Other: ________________

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What instruments/procedures were used to diagnose the disability?

X	INSTRUMENT / PROCEDURE	ADDITIONAL NOTES
	Interviews with the student	
	Interviews with other persons	
	Developmental history	
	Behavioral observations	
	Educational history	
	Medical history	
	Other tests etc.:	

Please describe the presenting symptoms of this disability:

Please identify the **functional limitations** listed below that are affected because of the diagnosis above and indicate the level of limitation. Requested accommodations must be tied to the functional limitations of the individual in the academic setting.

X	LIFE ACTIVITY	NO IMPACT	MODERATE	SEVERE	N/A
	Learning				
	Concentrating				
	Memory				
	Sleeping				
	Eating				
	Social Interacting				
	Managing internal distraction				
	Managing external distractions				
	Timely submission of assignments				
	Attending class regularly & on time				
	Making and keeping appointments				
	Managing stress				
	Organizing				
	Other:				

Based on the functional limitations listed above, what accommodations would the student like to discuss with the Disability Resource Center about receiving at SUNY New Paltz?

X	POSSIBLE ACCOMMODATIONS	RATIONALE
	Extended Testing Time: 1.5x time ___ 2x time ____	
	Alternative Testing Location	
	Screen Reader	
	Note Taking Support	
	Scribe	
	Computer for written exams	
	Use of a Basic Calculator	
	Books and Printed Documents in Alternate Formats: Audio ___ Braille ___ Enlarged font size (what size? _____)	
	ASL Interpretation ____ Captioning Services _____	
	Wheelchair Accessible Desk	
	Accessible Technology:	
	Other:	

Is this student currently taking medication for this disability? Yes _____ No _____

If yes, please list the pertinent medications:

Do limitations/symptoms persist even with medication? Yes _____ No _____

If yes, please explain:

How long do you anticipate the student will be impacted by this disability?

Six Months ______ One Year ________ Ongoing ______

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In the boxes below, describe how the recommended accommodations will minimize the barriers and symptoms of the disability, and provide evidence/explain why the accommodations are necessary.

Presenting symptoms of the disability:
Functional limitations caused by the disability:
How the accommodations will mitigate symptoms:
Please provide evidence/explain why the accommodations are necessary:

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CERTIFICATION

Certification of the Disability and the need for the Requested Accommodations

Signature: ____ Date: ________________

Print Name: ____

Credentials/Title: __________________________________ License #: ________________

Agency Name: ____

Street Address: ____

City: _____________________________ State: ___________ Zip Code: ______________

Phone: ___________________ Email: ____

Email the completed form to:

DRC@newpaltz.edu

Please attach an image of your Business Card
or use your Agency Stamp in the box below

If you have any questions about this form or its usage, contact the Disability Resource Center at DRC@newpaltz.edu