New Paltz
STATE UNIVERSITY OF NEW YORK

Disability Verification

Academic Accommodations

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 Physician 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.

Please type or print clearly

Please complete the following form for: _____, who has requested disability related services and accommodations from our office.

Request is being made for: **Semester:** Fall 20_____ Spring 20 _____

Diagnosis/DSM 5 Diagnosis: _____

_____

Date of Diagnosis: _____Date of your last contact with the student: _____

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

_____ Weekly _____Bi-Weekly _____Monthly _____Other: _____

What instruments/procedures were used to diagnose the disability? _____

	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:_____

_____

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Please identify the **functional limitations** listed below that are affected because of this diagnosis 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 to 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 are recommended?

X	RECOMMENDED ACCOMMODATION	RATIONALE
	Extended time for tests _____1 ½ _____ double	
	Small group testing	
	Private testing	
	Reader for tests	
	Note taker or Computer App to Audio Record	
	Scribe	
	Computer with spell check	
	Use of Basic Calculator	
	Books and printed documents in alt. format ___Audio ___Braille ___Enlarged font size _____	
	____ASL _____Captioning Services	
	Captioning of videos, etc.	
	Wheelchair accessible desk	
	Accessible technology:	
	Other:	

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Is this student currently taking medication for this disability? _____Yes _____No
Please list medications: _____

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

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

_____ Six Months _____ One Year _____ Ongoing

Please describe how the requested accommodations will minimize the barriers and symptoms of the disability and provide evidence and explain why the accommodations are necessary.

Presenting Symptoms of the Disability
Functional Limitations caused by the Disability
How the Accommodation will mitigate symptoms
Please provide evidence and 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: _____

Return this form to:

SUNY New Paltz
Disability Resource Center
HAB 205
1 Hawk Drive
New Paltz, NY 12561
(845) 257-3020
(845)257-3952 (Fax)

Please attach your Business Card

IF FAXED, ORIGINAL FORM MUST ALSO BE MAILED TO THE ABOVE ADDRESS