

## 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: \_\_\_\_\_



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:	

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

# CERTIFICATION

## Certification of the Disability and the need for the Requested Accommodations

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Credentials/ Title: \_\_\_\_\_ License #: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

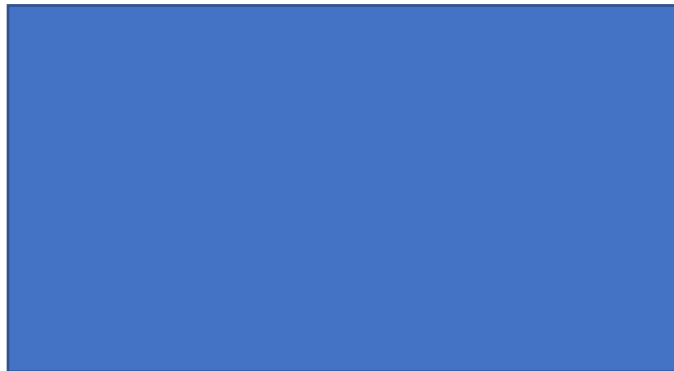
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**