SUNY BROOME | ACCESSIBILITY RESOURCES OFFICE

ARO is located on the ground floor of the Library, L017. For appointments and information, call 607-778-5150, VP 607-238-2714 or email aro@sunybroome.edu

Hearing and Vision Provider Form

A licensed provider (e.g., Audiologist, Doctor of Audiology, Optometrist, Optician, Ophthalmologist, etc.) may use this form to provide information related to the student's hearing/vision and personal assistive technology or personal devices (if applicable). This information will be used in conjunction with a student interview to begin assessing the functional impact of the student's disability and appropriate equal access academic accommodations and which types of potential assistive listening systems/ assistive technology may be appropriate and if additional technology is needed to provide equal access. Please comment on all sections.

Forms may be completed electronically, but must include either an **original signature** or **office stamp** to be authenticated. **FORMS WITHOUT THESE WILL NOT BE REVIEWED.**

Student's Legal Name: _____

Student's Preferred Name and Pronouns: _____

Student's Date of Birth: _____

Part I: Diagnosis Information

1. Student's Name: _____
2. Student's Diagnosis:

_____

3. Date of Original Diagnosis:_____
4. Date of Last Visit: _____
5. Is the student currently under your care: ☐ Yes ☐ No

6. If you did not provide the original diagnosis, can you confirm?

☐ I provided the diagnosis ☐ Yes, I can confirm ☐ No

7. Please describe the functional impact experienced by the student in relation to their diagnosis(es) as it pertains to an **academic setting** (e.g., impact on studying, course materials, lectures, etc.)

_____

_____

_____

_____

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8. Please describe the functional impact experienced by the student in relation to their diagnosis(es)as it pertains to **daily living** (e.g. eating, sleeping, transportation, recreation).

_____

_____

_____

_____

9. Any additional information the ARO office should be aware of:

_____

_____

_____

_____

If available, please attach the most recent evaluation and specific device details to clarify responses.

Part II: Assistive Technology related to Hearing (if applicable):

a. Brand: _____

b. Make: _____

c. Model: _____

d. Telecoil compatible : _____

e. Bluetooth compatible: _____

f. Mobile app: _____

g. If applicable: If the device is not telecoil compatible, please provide information that would allow the device to be telecoil compatible. Please include product name, cost, where/how to purchase and estimate for delivery: _____

h. If needed, does the student need to schedule an appointment to connect/program devices/

newly ordered technology to their personal device? □YES □NO

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Part III: Assistive Technology related to Vision (if applicable):

1. Any personal device/system/technology used by the student to provide equal access, please list it below. (E.g., screen readers, magnifiers, braille displays, etc.)

_____

_____

_____

_____

Provider's Contact Information:

Name and credentials: _____

Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): _____

Address: _____

Fax and/or email address: _____

Telephone Number: _____

Professional Signature: _____

License Number and State: _____

Date: _____