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

Autism Provider Form

Students with documented long-term or permanent disabilities or serious medical conditions may qualify for

equal access accommodations. In lieu of documentation of diagnostic testing, students may submit this form in order to establish eligibility with an Autism diagnosis.

This form must be submitted by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title, and license or certification credentials must be stated in the documentation, dated, signed and specifically addressed to the ARO. Forms completed by relatives will not be accepted.

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 Information

1. Student's Legal Name: ______________________________
2. Student's Preferred Name and Pronouns: ______________________________
3. Student's Date of Birth: ______________________________
4. Student's SUNY Broome B#: ______________________________

Provider/Student Relationship

1. How long have you been working with the student? ______________________________
2. When did you last see the student? ______________________________

Diagnostic Information

3. Does the student have a confirmed diagnosis of Autism? ☐YES ☐NO

4. Were you the provider who diagnosed the student with Autism? ☐YES ☐NO

If No, can you confirm the student's Autism diagnosis? ☐YES ☐NO

5. Does the student have any additional diagnoses? ☐YES ☐NO ☐UNKNOWN

If yes, please list below:

____

6. How was the diagnosis of Autism determined and when? Please indicate if testing was a comprehensive psychological evaluation, ADOS-II, or derived in any other means.

____

____

____

____

7. Please describe the functional impact experienced by the student in relation to their Autism diagnosis as it pertains to an **academic setting** (e.g., impact on studying, test taking, note-taking).

____

____

____

____

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

____

____

____

____

9. Please describe all current treatments and management strategies (e.g., medication, stress-reduction, resources, coping strategies, on-going therapeutic services).

____

____

____

____

10. If there is any other pertinent information you would like to share with ARO staff, please list below.

____

____

____

____

Provider's Contact Information:

3. Name and credentials: ____
4. Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): ______________
5. Address: ____
6. Fax and/or email address: ____
7. Telephone Number: ____
8. Professional Signature: ____
9. License Number and State: ____
10. Date: ____

If you would like a fillable version of this document, please contact the Accessibility Resources Office at aro@sunybroome.edu