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

Chronic Health Provider Form

A licensed medical provider (e.g., physician, neurologist, nurse practitioner, oncologist) may use this form to provide information related to the student's chronic health medical disability. 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. Please comment on all sections. In lieu of completing this form providers may also provide a separate letter outlining the functional impact of the student's chronic illness.

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.**

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. What is the Chronic Health diagnosis you are treating the student for?

_____

4. Were you the provider who diagnosed the student with this condition? ☐YES ☐NO If

No, can you confirm the chronic health diagnosis? ☐YES ☐NO

_____

5. Does the student have any additional diagnoses (e.g., ADHD, mental health, Autism, learning disabilities)? ☐YES ☐NO ☐ UNKNOWN

If Yes, please list below:

_____

_____

_____

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

_____

_____

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

_____

_____

_____

_____

8. Is the student currently prescribed current medication? ☐YES ☐NO

   Does the prescribed medication have any side effects that functionally impact their academics or daily living?

_____

_____

_____

_____

9. Other current treatments and management strategies (e.g., infusions, frequent appointments, physical therapy, injections).

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10. Does the student use any assistive medical devices (e.g., walker, pacemakers, insulin pump, hearing aids)?

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11. Is the student's disability cyclical or episodic in nature? ☐YES ☐NO

If yes, please provide details regarding the functional impact on their academics or daily living.

_____

_____

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_____

1. Name and credentials: _____
2. Area of medical specialization: _____
3. Fax and/ or email address: _____
4. Telephone Number: _____
5. Professional Signature: _____
6. Date: _____

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