SUNY BROOME | ACCESSIBILITY RESOURCES OFFICE

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Temporary Disability Provider Form

A licensed provider (e.g., MD, NP, psychiatrist, neuropsychologist, psychotherapist) must provide information related to the student's need for accommodations necessitated by their temporary disability. This information will be used with a student interview to begin assessing the functional impact of the student's disability and appropriate equal access accommodations.
Forms must include either an original signature or office stamp to be authenticated.
FORMS WITHOUT THESE WILL NOT BE REVIEWED.

Student Information

Legal Name: _____

Preferred Name and Pronouns: _____

Date of Birth: _____

B-Number: _____

The above student reports being diagnosed with a temporary physical or mental disability which substantially limits one or more major life activities.

Part I: Diagnosis Information

1. Please identify the temporary medical condition, injury, or disability for which you are treating the student.

_____

2. Date of Onset or injury: _____

3. Date of Last Visit/surgery/procedure: _____

4. Please provide the anticipated duration of the condition or recovery period:

_____

5. Please describe the student's current functional limitations resulting from the condition or injury. Please focus on what the student is currently limited or restricted from doing rather than solely on the diagnosis.

_____

_____

6. Please describe how the student's temporary condition and resulting functional limitations may currently impact participation in an academic setting.

_____

_____

7. Does the condition currently limit the amount of time the student can safely or reasonably engage in any of the following activities?
If limitations are present, please provide relevant parameters when medically appropriate (e.g., maximum duration, distance, weight, or frequency):

Sitting: _____

Standing: _____

Walking: _____

Writing/Typing: _____

Lifting/Carrying: _____

Using stairs: _____

8. Please list any mobility or assistive medical devices that the student is using?

_____

We appreciate you taking the time to complete this form.

<u>Provider Information</u>

Name of Provider: _____

Title:_____

License/Certification#:_____Expiration date: _____

Address:_____

Phone:_____

Email:_____

Provider's signature_____ Date: _____

Please return the completed form to:

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