Practitioner's Verification of Diagnosis

BOROUGH OF MANHATTAN
COMMUNITY COLLEGE
OFFICE OF ACCESSIBILITY
199 Chambers St., Suite N360
p. 212.220.8180

Student Name: _____

CUNYFirst ID# ___ ___ ___ ___ ___ ___ ___

Today's Date: ___ /___ /_____

This document must be completed by a licensed health professional only.

The Office of Accessibility (OA) at Borough of Manhattan Community College requires that students with a diagnosis which significantly impacts a major life activity submit documentation from a licensed health professional (physician, psychiatrist, or other specialist in order to establish eligibility for accommodation. The documentation must display the impact of the student's diagnosis on the educational experience and recommend the accommodations necessary to provide the student equal access in the academic setting.

DIAGNOSIS INFORMATION

Diagnosis in the area(s) of: ☐ ADHD ☐ Psychiatric ☐ Learning ☐ Medical

Primary Diagnosis(es) and results of evaluation (medical / DSM-IV or -V): _____

_____

Date of establishment / Age of onset ___ /___ /_____ Diagnosed by (provider's name) _____

Initial evaluation method(s): _____

Date of most recent evaluation ___ /___ /_____ Evaluation type: ☐ Psycho-educational ☐ Disability-related

Evaluation method(s): _____

Schedule for re-evaluation: _____

BACKGROUND HISTORY

_____

_____

_____

_____

_____

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EVALUATION PROCEDURES

Please list assessment or evaluation procedures, results, and any additional information related to the evaluation of the student's disability. (e.g. specific testing, weekly therapy, check-in appointments)

CURRENT IMPACT OF DIAGNOSIS

Please describe the student's condition. We ask that you include how the condition impacts the student and the student's ***educational history,*** *level of impairment,* ***progress and/or treatment as applicable.***

Severity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

IMPACT ON MAJOR LIFE ACTIVITY IN ACADEMIC SETTING

Does the diagnosis constitute a *current and substantial* limitation on a major life activity (i.e. learning)?

☐ YES ☐ NO

Please describe the limitations on learning and the degree to which the student's disability impacts academic performance and the student's ability to meet the demands of the academic program.

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_____

CURRENT MEDICATIONS AND TREATMENT

Please list any prescribed medications, their dosages, and any adverse side effects, if applicable.

_____

_____

_____

_____

_____

Condition is: ☐ Stable ☐ Prone to exacerbation ☐ Permanent/chronic ☐ Temporary

RECOMMENDATIONS / ADDITIONAL COMMENTS

Please provide a list of recommended accommodations and how they will address the student's specific needs for a fair and equal opportunity to learn relative to same-aged college peers. Specific accommodations will be determined and approved by BMCC's Office of Accessibility.

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EVALUATOR QUALIFICATIONS

I understand that the information provided will become part of the student record and may be released to the student upon the student's written request.

Printed Name of Verifying Evaluator _____ Signature _____

Title _____ License Number _____ Date ___ /___ /_____

Address _____ Phone _____

City, State, Zip Code _____ Fax _____

Please add your licensed provider stamp. If this is not possible, please attach a copy of your business card on a separate sheet.