



State University of New York

Upstate Medical University

Student Support Services

155 Elizabeth Blackwell Street, Syracuse, NY 13210

Summary for ADHD Documentation

Student

Name: Last _____ First _____ MI _____

Date of Birth _____ Phone _____

Address _____

Dates(s) of evaluation: _____

Certifying Professional

Name _____

Professional title _____ Highest degree _____

Phone _____ Email _____

Address _____

License/certification, number and state _____

Diagnosis (es):

Conditions/causes ruled out:

In your opinion, does any diagnosed condition above *substantially limit a major life activity* and thereby rise to the level of disability? Yes ___ No ___ Not sure ___

If yes, indicate which one(s) with an asterisk above and indicate the major life activity(ies) here:

Recommended accommodation(s) if any:

(Include a description of specific functional limitations and a rational for each suggested accommodation in the full report.)

In your opinion, does this student represent a potential danger to self or others, including patients under his or her care in a medical setting? ___ Yes ___ No ___ not sure

(Please explain a "no" or "not sure" in your full report or on separate letterhead.)

Signature _____ Date _____