



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 rationale 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 "yes" or "not sure" in your full report or on separate letterhead.)*

Signature \_\_\_\_\_ Date \_\_\_\_\_