DISABILITY SUPPORT SERVICES - STUDENT SUCCESS CENTER
766 Irving Ave. • 130 Health Science Library • Syracuse, NY 13210
T: 315.464.8855 F: 315.464.5431 *stuserve@upstate.edu*

UPSTATE MEDICAL UNIVERSITY

SUMMARY FOR LD DOCUMENTATION

STUDENT

Name: Last: _____ First: _____ M.I.: _____

Address: _____ Telephone #: (_____) _____

City: _____ State: _____ Zip: _____ Date of Birth: _____/_____/_____

Date(s) of evaluation: _____

CERTIFYING PROFESSIONAL

Name _____

Professional title _____ Highest degree _____

Telephone #: (_____) _____ Email _____

Address _____

_____

License/certification, number and state _____

Diagnosis(es):

_____

_____

Conditions/causes ruled out: _____

_____

In your opinion, does the diagnosed condition listed 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 Accomodations, 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 individual 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 "no/ sure" in your full report or on separate letterhead.

Signature _____ Date _____

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