

STUDENTS WITH DISABILITIES - INFORMATION FORM *(Completed by Student)*

Name: Last: _____ First: _____ M.I.: _____
Address: _____ Telephone #: (____) _____
City: _____ State: _____ Zip: _____ Today's date: ____/____/____
College: College of Nursing College of Health Professions Program name: _____
 College of Medicine College of Graduate Studies Department Name: _____
Student Status: Matriculated or Non-Matriculated Entering Year: _____
 Full-time Student or Part-time Student Class of: _____

Nature of Disability *(check all that apply)*

Hearing Disability Learning Disability Psychiatric Disability ADHD Physical Disability
 Visual Disability Other: _____

I was first professionally diagnosed with _____ *(state specific diagnosis)* in
_____ *(month)*, _____ *(year)*. *(Attach additional pages for multiple diagnoses)*

The original diagnosis was made by:

Name of qualified professional: _____
Type of health care provider: _____
Current Address and Phone Number: _____

What treatment(s)/medication(s) have you pursued? Provide the name and qualifications of the treating professional, the time frames in which you were treated, the impact of the treatment on your condition, and an explanation for why a treatment may have been discontinued *(Attach additional pages as needed)*.

Requested accommodation(s). Include a description of the specific functional limitations and a rationale for each required accommodation.

Please describe any previous accommodations you have requested during your educational career. Provide a description of the programs/services attended as well as documentation from the institution granting or denying accommodation.

No Elementary school High school College Other: _____

Description:

Did you receive formal testing accommodations for classroom examinations and/or admissions tests throughout your educational career? Please check all that apply and additionally provide a description of the accommodation?

No Elementary school High school College Other: _____

SAT (*attach copy of test scores*) ACT (*attach copy of test scores*) MCAT (*attach copy of test scores*)

Other: _____

Description:

Note: You must provide copies of test scores and supporting documentation for any accommodations that you have received. You must provide transcripts from undergraduate institution if the nature of your disability is a learning disability, psychiatric disability or ADHD. To assist in establishing a childhood onset of symptoms, it is also recommended that you provide report cards or transcripts from elementary school, middle school and high school as well.

Please return this form as soon as possible to:

Katherine Daley, Coordinator, Disability Support Services

SUNY Upstate Medical University, Student Success Center, Room 130 Health Sciences Library

766 Irving Avenue, Syracuse, NY 13210.

Ph: (315-464-8855) Email: StuServe@upstate.edu