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 PHYSICAL/SENSORY DISABILITY DOCUMENTATION

STUDENT

Name: Last: ______________________ First: ______________________ M.I.: ____________

Address: ______________________________________ Telephone #: ( ) ______________

City: ______________________ State: __________ Zip: ______________ Date of Birth: ____/____/____

CERTIFYING MEDICAL PROFESSIONAL

Name ____

Professional title ______________________________ Degree ______________

Telephone #: ( ) ______________ Email ______________________________

Address ____

____

License, number and state ____

Report Date ______________ Date of first student contact ______________ Date of last student contact ______________

Diagnosis(es):

____

____

____

____

In your opinion, does any 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 condition(s) with an asterisk above, and report here which major life activity(ies) is substantially limited:

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____

Brief History *(include include onset of symptoms, progression to date, any trauma involved, and any previous accommodations)*

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19-0370 Rev. 10/2019 Review 10/2019

Functional limitations *(indicate degree of limitation for each – mild. moderate, severe):*

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Please include any relevant test data with this form as well as any additional clinical comments on letterhead

Suggested Accomodations *(provide brief rationale for each suggestion):*

____

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____

Is the course of this condition (or set of conditions) considered:

☐ Permanent and relatively stable ☐ Permanent and variable ☐ Permanent and Progressive ☐ Temporary

If temporary, please indicate estimated time of impairment/disability: ______________________

If variable, please characterize the expected fluctuations

____

____

____

Does this student take medication or undergo treatment that may adversely affect performance or behavior? ☐ Yes ☐ No

If "yes," please describe:

____

____

____

In your opinion, how often should this-student re-evaluated? ☐ 6 mos ☐ 1 year ☐ 2 years ☐ Other (specify) ____________

Safety

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 "not sure" on letterhead.

Signature ____ Date ____________________