NYU | Moses Center for Student Accessibility

The Moses Center for Student Accessibility
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Certification of Disability

Instructions

To the Student:

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY BY YOUR CLINICIAN.

If this form is completed by anyone other than a qualified licensed professional, the information provided may not be used to support your accommodation request and CSA reserves the right to request additional documentation. Since a request for additional information can result in a delay in your request for services, you are strongly urged to have the form completed by a qualified clinician who will include all requested information.

THIS FORM MAY NOT BE USED AS SOLE DOCUMENTATION FOR LD OR ADHD, but may supplement a current psycho-educational or neuropsychological evaluation.

To the Evaluator:

The student named below has represented that s/he has a disability which will require certain accommodations in order to participate in a program or activity at New York University. The information you provide will be used to determine the appropriateness of the requested accommodations.

Please take the time to complete this form and thoroughly answer all questions.

You may fax us a copy, but our records must include an original with your signature. We cannot accept substitutions for this form but you may provide supplemental information on official letterhead. Please contact us with any questions. All information provided to us is confidential. With the student's permission, we may contact you directly for additional information to assist us in making a determination.

Guidelines for Additional Documentation:

- For visual impairments: Please attach acuity information.
- For hearing impairments: Please attach audiogram.
- If you have received this form to document learning disabilities and/or ADHD a recent neuropsychological or psycho-educational evaluation must be attached.

Student's Name: _____

Student ID # _____

Name of Student's Diagnosis (with DSM-V / ICD-10):

_____

Date of Onset: _____

Date last seen: _____

Summary of Assessment:

Current Status of Diagnosis, i.e. is it currently active? _____

How long will this condition likely exist?

What are the individual's current functional limitations? Related Symptoms?

Are there time, conditions, or circumstances which exacerbate the condition?

Current Treatment Plan:

Current Medications:

Potential side effects of Medication(s):

Please feel free to advise on academic, housing, dining or other accommodations you feel would afford this student meaningful access to education:

Name and Title of Physician or Licensed Clinical Provider:

_____

Address:_____

Telephone:_____ E-mail:_____

Physician/Provider Signature (stamped signatures are not solely accepted):

X_____ Date:_____

Physician/Provider Identification Number:_____