Bronx Community College

Division of Student Affairs
Office of disAbility Services
Loew Hall Room 211, 2155 University Avenue, Bronx, NY 10453
(718)289-5874 phone

MEDICAL DOCUMENTATION

Please present to the doctor who is entrusted with your care, be certain s/he signs AND STAMPs page two of this form. Thank you for your cooperation and prompt response.

STUDENT: _____ CF ID#_____
I authorize the release of this information to the Office of Disability Services

Signature: _____ Date: _____

ATTENTION: _____
(Physician, Clinic, Psychologist, Therapist, School, Agency)

The student named above has applied for services and accommodations that are provided by the College in compliance with the **Americans with Disabilities Act**. These services and accommodations are available to students with disabilities or medical conditions that substantially interfere with their ability to do course work or substantially limit their involvement in other aspects of college life. To effectively respond to this student's request, your assistance is required.

The **ADA** defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activity, such as; seeing, speaking, hearing, walking, breathing, performing manual tasks, caring for oneself, learning and working.

Please specify functional limitations or restrictions that are the result of the student's medical or psychological condition. Some examples are: limited mobility; impaired vision, hearing or speech; memory/concentration difficulties; affective impairment; cognitive impairment; chronic fatigue; restricted physical activity, use of stairs, prolonged sitting/standing; developmental delay, social anxiety. **Please use additional pages for information you deem essential to documenting this student's disability and functional limitations.**
We may contact you for additional information in the process of determining eligibility for services and accommodations.

BE SPECIFIC IN YOUR DESCRIPTIONS AND EXPLANATIONS. PLEASE PRINT CLEARLY.

The information you provide is held in confidence per ADA guidelines and is used only to plan accommodations.

Diagnosis / Description of disability/condition: (if a Psychiatric disability, you may use DSM-V descriptor)

_____

_____

_____

_____ **Date of Diagnosis: _____**

Functional Limitations, e.g., **physical** – hand function, mobility, hearing, vision limitations; **cognitive** – learning, memory, concentration problems; **interpersonal** – difficulty interacting with others; **psychological** (be specific in all indications)

_____

_____

_____

What accommodations, if any, do you recommend? For example, limited physical exertion, part-time study, etc.

_____

_____

_____

Is this disability or impairment temporary (less than 6 months) _____ or persistent_____?

Medications (please include any major side effects_____

Is the student currently under your care? YES ___ NO___ Is this ongoing treatment? YES ___ NO ___

Is the person named above able to undertake college study at this time? YES ___ NO ___

Name of person completing this form: _____ Title: _____

Agency/ Affiliation: _____ Telephone: _____Date:_____

Signature: _____**Agency Stamp:**