The City College of New York
Division of Student Affairs
Willie Administration Building, The City College of New York
160 Convent Avenue New York, NY 10031 (212) 650-5426

AccessAbility Center
North Academic Center, Room 1/218
Convent Avenue at 138th Street
New York, New York 10031
Voice: 212-650-5913 Fax: 212-650-5772
TTY/TTD: 212-650-6910 disabilityservices@ccny.cuny.edu

REQUEST FOR DISABILITY DOCUMENTATION PROVIDER FORM

INSTRUCTIONS FOR PROVIDER

Students who wish to register with The AccessAbility Center/ Student Disability Services (AAC/ SDS) at City College must provide disability documentation from a qualified professional. A qualified professional is an individual who is credentialed in the area(s) of which he/ she is assessing and diagnosing conditions. Your patient, who is a student, has requested that City College provide him/her with appropriate and reasonable accommodations, in order to receive meaningful and equal access to the College's programs, services, and activities. This form shall serve the purpose of obtaining information regarding the following:

1. A detailed description of the specific physical and/or mental health condition(s) that affect the student's ability to perform major life functions and engage in programs, services, and activities;
2. appropriate and reasonable accommodations warranted; and
3. the relationship between the requested accommodation(s) and the functional impact of the disability/ impairment.

Please return this completed form to the patient.

Name of Patient (Please Print): _____ **Date of Birth**: _____

Name of Provider: _____

Address of Provider: _____

_____

Telephone Number of Provider: _____

1) Please state patient's medical and/or mental health condition(s):

REQUEST FOR DISABILITY DOCUMENTATION (Continued)
PROVIDER FORM

2) Please provide a detailed description of the specific physical and/or mental health functional limitations affecting the patient's ability to perform major life activities and engage in academic programs, services, and activities. Please describe how the disability/impairment affects the patient's daily functioning, particularly in an academic setting.

3) Indicate whether the patient's condition(s) is permanent, chronic, or temporary, and the onset, frequency and duration of episodes. If the patient's condition(s) is temporary, please state its anticipated duration.

4) Indicate what treatment if any the patient is receiving and associated with his/her medical and/or mental health conditions(s) including, but not limited to, medications or therapy. Please include relevant information regarding the side effects.

5) Please describe the appropriate and reasonable accommodation(s) needed by the patient, and the relationship between the requested accommodations and the functional impairment/disability.

Provider's Signature: _____ **Date:** _____

Provider's Credentials: _____

Provider's License Number: _____

Please attach additional documentation if needed on letterhead and signed by the provider.