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

The AccessAbility Center/Student Disability Services
North Academic Center, Room 1/218
New York, New York 10031
Voice: 212-650-5913
Fax: 212-650-5772
TTY/TTD: 212-650-8441
Email: 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 The City College of New York must provide disability documentation from a qualified professional. A qualified professional is an individual who is credentialed in the area(s) for which he/ she is assessing and diagnosing conditions. Your patient, who is a student, has requested that City College provide him/her with accommodations and services, in order to receive meaningful and equal access and full participation to the College's programs, services, and activities. This form shall serve the purpose of obtaining information regarding the following:

1. A description of the physical and/or mental health impairment(s) that impacts the student's ability to perform major life activities and engage in programs, services, and activities;
2. Academic adjustments and auxiliary aids that are 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 (i.e., student) upon completion.

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

Provider's Name:_____
Provider's Address:_____
Provider's Telephone and Fax:_____
Provider's Email Address:_____

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

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REQUEST FOR DISABILITY DOCUMENTATION (Continued)
PROVIDER FORM

2) Please provide a description of the 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.

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

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

5) Please describe the academic adjustments and auxiliary aids needed by the patient. There must be a relationship between the requested accommodations and the functional impact of the 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.