NYU | Moses Center for Student Accessibility

The Moses Center for Student Accessibility
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Phone (212) 998-4980 mosescsa@nyu.edu

Supporting Documentation for Consideration of Accommodation

To the Student:

This form should be filled out in its entirety by your clinician.

To the Evaluator:

The NYU student named below has requested accessibility accommodations. 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 to the best of your ability. If your relationship to the student is new, please provide whatever information is available to you at this time. You may use language such as “student reports” or “evaluating for”.

We will accept this signed form via email to expedite review of the student’s request. With the student’s permission, we may contact you directly for additional information to assist us in making a determination. All information provided to us is confidential.

A few guidelines:

- For visual impairments: Acuity information recommended.
- For hearing impairments: Audiogram with summary findings recommended.

Student's Name:

Student NYU ID:

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

Date of Onset:

Date last seen:

Summary of Assessment:

Current Status of Diagnosis (i.e. currently active/in remission)?

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 may also list the accommodations the student reports having requested.

Name and Title of Physician or Licensed Clinical Provider: **All Information Required**

_____

Address:_____

Telephone:_____E-mail:_____

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

X_____Date:_____

Physician/Provider Identification Number:_____