



**Services for Students with Disabilities  
UU119**

PO Box 6000  
Binghamton, New York 13902-6000  
607-777-2686 Voice, Fax: 607-777-6893  
Email: [ssd@binghamton.edu](mailto:ssd@binghamton.edu)

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A licensed medical provider (e.g., physician, neurologist, nurse practitioner, oncologist) may use this form to provide information related to the student's chronic health medical disability. This information will be used in conjunction with a student interview to begin assessing the functional impact of the student's disability and appropriate equal access academic accommodations.

6. Please describe the functional impact experienced by the student in relation to their chronic illness diagnosis(es) as it pertains to an \_\_\_\_\_ (e.g., impact on studying, test taking, note-taking).

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7. Please describe the functional impact experienced by the student in relation to their chronic illness as it pertains to \_\_\_\_\_

10. Does the student use any assistive medical devices (e.g., walker, pacemakers, insulin pump, hearing aids)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Is the student's disability cyclical or episodic in nature?      YES      NO

If yes, please provide details regarding the functional impact on their academics or daily living.

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\_\_\_\_\_

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*Forms may be completed electronically, but must include either an \_\_\_\_\_ or \_\_\_\_\_ to be authenticated.*

Name and credentials: \_\_\_\_\_

Area of medical specialization: \_\_\_\_\_

Address: \_\_\_\_\_

Fax and/or email address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Professional Signature: \_\_\_\_\_

License Number and State: \_\_\_\_\_

Date: \_\_\_\_\_