

Autism Provider Form

Students with documented long-term or permanent disabilities or serious medical conditions may qualify for equal access accommodations. In lieu of documentation of diagnostic testing, students may submit this form in order to establish eligibility with an Autism diagnosis.

This form must be submitted by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title, and license or certification credentials must be stated in the documentation, dated, signed and specifically addressed to SSD. Forms completed by relatives will not be accepted.

*Forms may be completed electronically, but must include either an **original signature** or **office stamp** to be authenticated. **FORMS WITHOUT THESE WILL NOT BE REVIEWED.***

Student Information

Student's Legal Name: _____

Student's Preferred Name and Pronouns: _____

Student's Date of Birth: _____

Provider/Student Relationship

1. How long have you been working with the student? _____

2. When did you last see the student? _____

Diagnostic Information

3. Does the student have a confirmed diagnosis of Autism? ☐ YES ☐ NO

4. Were you the provider who diagnosed the student with Autism? ☐ YES ☐ NO

If No, can you confirm the student's Autism diagnosis? ☐ YES ☐ NO

5. Does the student have any additional diagnoses? ☐ YES ☐ NO ☐ UNKNOWN

If yes, please list below:

6. How was the diagnosis of Autism determined and when? Please indicate if testing was a comprehensive psychological evaluation, ADOS-II, or derived in any other means.

7. Please describe the functional impact experienced by the student in relation to their Autism diagnosis as it pertains to an **academic setting** (e.g., impact on studying, test taking, note-taking).

8. Please describe the functional impact experienced by the student in relation to their Autism diagnosis as it pertains to **daily living** (e.g. eating, sleeping, transportation, recreation).

9. Please describe all current treatments and management strategies (e.g., medication, stress-reduction, resources, coping strategies, on-going therapeutic services).

10. If there is any other pertinent information you would like to share with SSD staff, please list below.

Please complete the Provider's Contact Information below, and return it to:

Services for Students with Disabilities -UU119
Binghamton University
P.O. Box 6000
Binghamton, NY 13902
Phone: 607-777-2686
Fax: 607-777-6893
Email: ssd@binghamton.edu

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Provider's Contact Information:

Name and credentials: _____
Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): _____
Address: _____
Fax and/or email address: _____
Telephone Number: _____
Professional Signature: _____
License Number and State: _____
Date: _____