

## **Chronic Health Provider Form**

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. Please comment on all sections. In lieu of completing this form providers may also provide a separate letter outlining the functional impact of the student's chronic illness.

*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'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. What is the Chronic Health diagnosis you are treating the student for?

\_\_\_\_\_

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

If No, can you confirm the chronic health diagnosis? ☐ YES ☐ NO

\_\_\_\_\_

5. Does the student have any additional diagnoses (e.g., ADHD, mental health, Autism, learning disabilities)? ☐ YES ☐ NO ☐ UNKNOWN

If Yes, please list below:

\_\_\_\_\_

\_\_\_\_\_

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6. Please describe the functional impact experienced by the student in relation to their chronic illness diagnosis(es) as it pertains to an **academic setting** (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 **daily living** (e.g. eating, sleeping, transportation, recreation).

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8. Is the student currently prescribed current medication? ☐YES ☐NO

Does the prescribed medication have any side effects that functionally impact their academics or daily living?

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9. Other current treatments and management strategies (e.g., infusions, frequent appointments, physical therapy, injections).

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

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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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**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](mailto:ssd@binghamton.edu)

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

**Provider's Contact Information:**

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

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

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

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

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

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

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

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