BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

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

Hearing and Vision Provider Form

A licensed provider (e.g., Audiologist, Doctor of Audiology, Optometrist, Optician, Ophthalmologist, etc.) may use this form to provide information related to the student's hearing/vision and personal assistive technology or personal devices (if applicable). 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 and which types of potential assistive listening systems/ assistive technology may be appropriate and if additional technology is needed to provide equal access. Please comment on all sections.

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: _____

Part I: Diagnosis Information

1. Student's Name: _____
2. Student's Diagnosis: _____
3. Date of Original Diagnosis:_____
4. Date of Last Visit: _____
5. Is the student currently under your care: ☐ Yes ☐ No
6. If you did not provide the original diagnosis, can you confirm?

   ☐ I provided the diagnosis ☐ Yes, I can confirm ☐ No

7. Please describe the functional impact experienced by the student in relation to their diagnosis(es) as it pertains to an **academic setting** (e.g., impact on studying, course materials, lectures, etc.)

_____
_____
_____
_____

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

_____
_____
_____
_____

9. Any additional information the SSD office should be aware of:

_____
_____
_____
_____

If available, please attach the most recent evaluation and specific device details to clarify responses.

Part II: Asssistive Technology related to Hearing (if applicable):

1. Brand:_____
2. Make: _____
3. Model:_____
4. Telecoil compatible:_____
5. Bluetooth compatible:_____
6. Mobile App:_____
7. If applicable: If the device is not telecoil compatible, please provide information that would allow the device to be telecoil compatible. Please include product name, cost, where/how to purchase and estimate for delivery.

   _____
   _____
   _____
   _____
8. If needed, does the student need to schedule an appointment to connect/program devices/ newly ordered technology to their personal device? ☐ Yes ☐ No

Part III: Asssistive Technology related to Vision (if applicable):

1. Any personal device/system/technology used by the student to provide equal access, please list it below. (E.g., screen readers, magnifiers, braille displays, etc.)

_____

_____

_____

_____

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

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Provider's Contact Information:

Name & Credentials: _____

Area of Specialization:_____

Address: _____

Fax and/or email address:_____

Phone: _____

License Number and State: _____

Signature: _____

Date:_____