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

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:

   _____

   _____

   _____

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).

_____

_____

_____

_____

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).

_____

_____

_____

_____

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?

_____

_____

_____

_____

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

_____

_____

_____

_____

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.

_____

_____

_____

_____

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

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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: _____