Disability Disclosure Consent Form  
(To be completed and signed by Student)

Dear (Licensed Professional): ______________________________ Date: ____________

I am requesting services from Student Access Office (SAO) at Adelphi University. In order to receive accommodations, SAO requires documentation of my disability. Services at SAO are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

☐ I hereby authorize you to complete the enclosed Questionnaire and release it to SAO.
☐ I also authorize you to speak with the SAO Director should further information be required.

Please submit the completed form to:

Rosemary Garabedian, Director  
By mail:  
Adelphi University  
Student Access Office  
1 South Ave  
Garden City, NY 11535  
By confidential fax: 516-877-3138

You may contact Ms. Garabedian with any questions (phone: 516-877-3145/ fax: 516-877-3138 or email: garabedian@adelphi.edu).

Thank you for your timely assistance with this matter.

Sincerely,

____________________________________  ____________________________  
Student Signature  Date

____________________________________  ____________________________  
Print Name  Adelphi ID#
Licensed Professional Questionnaire

This form must be completed by the licensed clinician or health care provider who is treating this patient for the diagnosis identified in this document. In order to best serve the student, please thoroughly complete all requested information.

Patient’s/Client’s name: _________________________________________________________
Clinician’s Name: _____________________________________________________________
Clinician’s State Licensure/Certification #: _______________________________________
Area of Specialty: ___________ Licensed Professional phone #: ________________

The person named on this form is requesting services from Student Access Office (SAO) from Adelphi University. SAO offers services to students who are considered disabled in the mandates of the Americans with Disabilities Act as Amended of 2008 (ADAAA). Under the ADAAA definition, a person with a disability is one with a physical, mental, emotional, or chronic health impairments that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentration, thinking, communicating and working. Major life activities also included bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (this is not an exhaustive list).

I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria:  Yes  □  No  □

If yes, please thoroughly complete this form to document the substantial limitations that are linked to the disability:

Diagnosis/description of disability: _______________________________________________
Please provide full DSM of ICD-9 code: ___________________________________________
Initial date of diagnosis: _________________________________________________________
Date of last clinical contact: _____________________________________________________
Expected duration of disability noted above is:

□  Permanent
□  Chronic
□  Long term (3 – 12 months)
□  Short term (60 – 90 days)
□  Temporary (1 – 60 days)

The extent of the disability is:

□  Mild
□  Moderate
□  Severe
• What are the frequency and duration of symptoms of the student’s conditions?
  □ Daily    □ 1x/week    □ 1-3x/week    □ 1x/month    □ 1-3x/year    □ Seasonal
  □ None - symptoms under control with medication

• Assessment Instruments and Results (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):

• Please describe the functional impact of the disability/symptoms on this individual's. Please be specific as to “the barrier to access in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act”. Avoid using language that suggests the request is based on comfort or preference needs:
  □ Daily Life

  □ Academic Experience

• Please describe the current treatment and medication regimen (including treating licensed professionals, frequency of treatment, medications, and side effects):
• Suggested accommodation(s) for the academic setting (please be advised that providing recommendations does not guarantee approval of requests):

• Additional information (please include any further details that will support the accommodation request and assist the disability provider in making an appropriate decision based on equal access):

______________________________  __________________________
Licensed Professional Signature  Date

______________________________
Licensed Professional Stamp