

**Syracuse University Center for Disability Resources**  
**Provider Verification Form for Students with Psychological/Attention Deficit Disorders**  
**Medical, Sensory and Health-Related Conditions**

**Students Name:**

**SU ID:**

**Campus or Home Address:**

**Contact Number#:**

**E-Mail:**

I authorize Syracuse University to receive information from the provider listed below. I also authorize my provider to discuss my disability/s and its impact relative to the educational environment with the appropriate University personnel. My signature also indicates that the appropriate healthcare provider or their designee answered the questions and signed this form. I understand that providing false information places me in violation of the Syracuse University Student Code of Conduct and subjects me to any applicable sanctions.

Provider Name:

Contact Information:

Student Signature:

Date:

To ensure the provision of reasonable and appropriate services for students with psychological, attention deficit, medical, sensory or health related conditions at Syracuse University, a licensed professional (e.g. physician, psychiatrist, psychologist or certified social worker) must provide current and comprehensive documentation of the student's disability/condition.

1. DSM-V/Medical Diagnosis:
2. Date of Diagnosis:
3. Date of your last contact with the student:
4. What instruments/procedures were used to diagnose the condition?
  
5. What major life activity does this condition impact?

6. Please describe the current symptoms of this condition and your on-going relationship regarding their treatment plan.

7. Is this student currently taking medication for this condition? No                      Yes

If yes, what is the medication? Please describe any possible side effects of the medication.

8. Please describe the impact of this condition in the educational environment so that we can determine if the specific academic adjustments and/or auxiliary aids are necessary to ensure equal access.

9. Are there any suggestions for this student that you can offer regarding strategies and/or adjustments to mitigate potential environmental barriers while they attend Syracuse University? If so, please specify below. Keep in mind, accommodations in the college environment focus on access, not student success or preference.

Please attach any additional documentation that you believe relevant to the development of this student's comprehensive academic adjustment plan.

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

Print Name and Title: \_\_\_\_\_

License# \_\_\_\_\_

Office Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Email or Fax Form to:**

[CDRspecialist@syr.edu](mailto:CDRspecialist@syr.edu) subject line: [student name]/Provider Verification Form

Fax (315) 443-1312

Questions, please call: (315) 443-4498