



Verification of a Physical, Medical or Sensory Disability

(DO NOT use for Learning Disabilities, ADD/ADHD, Psychological or other cognitive disorders)

Student Disability Services at Cornell University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. A disability must **substantially limit** one or more major life activity, such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, and working. Current and comprehensive disability documentation from a health-care provider (who is not a relative of the student) is required to assist with the provision of appropriate and reasonable accommodations and/or auxiliary aids. For hearing impairments, include a recent audiology report. For visual impairments, include results of a recent eye exam. Additional documentation may be required.

To be completed by a certified health care professional.

All items are required. Please print legibly. Include additional pages, if needed.

Physician's Name: _____ Today's Date: _____
Address: _____

License/Cert: #: _____ Phone: _____ Fax: _____

Student's Name: _____ Date of Birth: _____
Complete Diagnosis: _____

Date of Dx: _____ Severity of condition (circle one): Mild Moderate Severe In Remission
Procedures/assessments used to diagnose this student's condition: _____

Treatment and/or medications currently being used: _____

Functional limitation(s) caused by this condition and/or its treatment: _____

Recommended accommodation and/or auxiliary aids (must be clearly linked to functional limitations): _____

Anticipated Duration of Accommodation: _____

Physician/Health Care Provider Signature: _____

I, _____, authorize the above health-care provider to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my permanent or temporary disability while a student at Cornell University.

Signature of patient: _____ Date: _____

If signed by person other than patient, state relationship and authority to do so.

Relationship: _____ Legal Authority: _____