FIT-ABLE Office
Office of Disability Services
fitable@fitnyc.edu
(212) 217-4091

Medical Information for Academic Accommodations Request

Instructions for Provider:

Students who wish to register with the Office of Disability Services (FIT-ABLE) at the Fashion Institute of Technology must provide disability documentation from a qualified professional. A qualified professional is an individual who is credentialed in the area(s) for which they are assessing and diagnosing conditions. Your patient, who is a student, has requested that the Fashion Institute of Technology provide them with accommodations and services in order to receive equal access and full participation to the College's programs, services, and activities. This form shall serve the purpose of obtaining information regarding the following:

1) A description of the physical and/or mental health impairment(s) that impacts the student's ability to perform major life activities and engage in programs, services, and activities.

2) Academic adjustments and auxiliary aids that are requested based on disability need.

3) The relationship between the requested accommodation(s) and the functional impact of the disability/impairment.

Please return the completed form to the FIT-ABLE office via mail, email or fax:

Office of Disability Services-FIT-ABLE
Fashion Institute of Technology, SUNY
227 West 27th Street, Room A570
New York, NY 10001

Email: fitable@fitnyc.edu
Phone: 212-217-4090
Fax: 212-217-4091

PLEASE NOTE: All fields should be filled and all questions answered completely. The FIT-ABLE office will request illegible and/or incomplete forms to be resubmitted.

Patient/Student Name: _____

Patient/Student Date of Birth: _____ **Patient/Student ID Number: @** _____

Date of Initial Contact with Student/Patient: _____ **Date of Last Contact:** _____

Healthcare Provider's Name: _____ **Specialty:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Diagnosis & Functional Impact:

1) Please provide a diagnostic statement with a date of initial diagnosis:

2) Please describe the symptom and treatment history- Indicate whether the student's disability/ impairment(s) is permanent, chronic or temporary. Please provide details of the onset, frequency, and duration of episodes. If the student's disability/impairment(s) is temporary, please state its anticipated duration:

3) Please provide a description of the physical and/or mental health functional limitations impacting the student's ability to perform major life activities and engage in an academic setting:

Current Treatment:

4) Please provide details of the student's current treatment plan- indicate what treatment, if any, the patient is receiving and associated with their disability/impairment(s). This may include, but not limited to medications or therapy. Please include relevant information regarding the side effects:

Accommodation Recommendations:

5) Please recommend specific academic accommodations that will assist in minimizing or alleviating the limitations related to the student's disability:

6) Please provide any additional information that you feel would be helpful in evaluating the student's request:

I certify that the statements in this form, as well as any documentation referred to or attached, are true and accurate.

Provider's Signature: _____ Date:_____

Provider's Credentials: _____

Provider's License Number:_____