



**Fashion Institute
of Technology**

Seventh Avenue at 27 Street
New York City 10001-5992
www.fitnyc.edu

FIT-ABLE
Room A570
p. (212) 217-4090
f. (212) 217-4091

Medical Information for Academic Accommodation Request

Dear Medical Professional,

This form is being sent on behalf of a current or entering student at the Fashion Institute of Technology (FIT). The student is requesting academic accommodations on the basis of disability or medical condition. The student has authorized you to release the information to the Office of Disability Services at FIT, as indicated on the attached release form.

Please respond to the questions on this form regarding the student's disability or medical condition to inform FIT's evaluation of the student's need for an accommodation and the nature of the accommodation the student requires. General statements without sufficient supporting information may limit FIT's ability to process this request.

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
Room A570
227 West 27th Street
New York, NY 10001
Fax: 212-217-4091
Phone: 212-217-4090
Email: fitable@fitnyc.edu

Name of Healthcare Provider _____

Specialty _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Student Name _____ Student's Date of Birth _____

Date of Initial Contact with Student _____ Date of Last Contact _____

License/Certification Number _____

Provider Signature or Stamp: _____

Diagnosis, Treatment, and Recommendations:

Diagnostic statement with date of initial diagnosis and the basis for the diagnosis (e.g., tests, physical exam, procedure)

Please describe the student's specific functional limitations and impact of the condition as well as level of severity in an academic setting.

Please describe the expected duration, stability, or progression of the diagnosis and associated functional limitations.

What specific academic accommodations would you recommend to assist in minimizing or alleviating the limitations related to the student's disability?

Please describe the treatment history.

What is the student's continued plan of care/treatment with you as their healthcare provider to supplement the recommended academic accommodation (e.g. current medications, other treatment plans)?

Please provide any additional information that you feel would be helpful for FIT 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.

Professional's Signature: _____ Date: _____

Please note: Forms that lack a signature or the information about provider credentials on page one will not be accepted. Additionally, documentation prepared by parents or relatives of the requesting student will not be accepted.