SUNY Cortland
Disability Resources Office

Documentation for Students with ADD/ADHD

To provide disability-related services, SUNY Cortland requires students to submit a detailed assessment by a qualified health professional verifying their disability.

Please have your provider complete this form and return it to:

Sue Sprague
Director, Disability Resources Office
SUNY Cortland
PO Box 2000 – B-1 Van Hoesen Hall
Cortland, NY 13045

Date: _____

Phone: _____

Health professional's name (please print): _____

Clinic name and address: _____

_____

Health professional's signature: _____

Student's name: _____

1. *ASSESSMENT*

What is the diagnosis? _____

_____

When was your initial diagnosis made? _____

_____

Is the patient/student currently under your care? _____

_____

When did you last see the patient/student? _____

_____

2. *MAJOR LIFE ACTIVITIES ASSESSMENT*

Please check all major life activities listed below that are affected as a result of the diagnosis.

Please indicate level of limitation.

1= Negligible 2= Moderate 3= Substantial

Level of Limitation	1	2	3
Writing			
Performing manual tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Taking exams			
Interacting with others			
Other:			

What are the functional limitations resulting from the diagnosis that impact on major life activities identified in #2?

_____

_____

Based upon the major life activities affected by the diagnosis, are there any accommodations within the context of the college that you can recommend for this student?

_____

_____

Medications: _____

Medication side-effects: _____

_____