Student Accessibility and Support Services

Directions for completing this form:
1. Download and save the form to your computer
2. Complete the fillable form
3. Submit the form by clicking the "email to SASS" button or return via email or mail

Documentation Form: Chronic Medical/Orthopedic Disability

Student's Name: _____

The student named above is applying for disability accommodations and services through Student Accessibility and Support Services (SASS) at Rider University. In order to determine eligibility, a qualified professional must certify that the student has been diagnosed with a chronic medical/orthopedic disability and provide documentation that it represents a substantial impediment to a major life activity. This documentation form was developed as an alternative to traditional diagnostic reports. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the SASS website (accessibility in order to view documentation guidelines. SASS expects the following in regards to this documentation form:

- The form will be completed with as much detail as possible.
- The diagnosis of the disability was derived through a formal assessment.
- The assessment information must be current.
- The form is being completed by an appropriate medical professional.
- The professional completing the form is not a family member of the student or has a personal or business relationship with the student.

What is the student's diagnosis?

What is the severity of the condition? ◯ Mild ◯ Moderate ◯ Severe

Explain the severity indicated above:

What is the expected duration? ◯ Chronic ◯ Episodic ◯ Short-term

Explain the duration indicated above:

The student's prognosis:

:

Provide information regarding the student's current symptoms and impact on daily functioning:

List the student's current medication(s), dosage, frequency, and adverse side effects:

In the event of an on campus emergency requiring evacuation (e.g. fire drill, bomb threat), will this student need assistance?

◯ Yes ◯ No

If **Yes**, please explain:

State the student's functional limitations specific to the academic setting and recommended accommodations.

Certifying Professional

Name and Title	Type of License or Certification

Company/Office/Institution Affiliation Name

Address	Phone #
City, State, Zip	Fax #
Signature of Certifying Professional	Date

Student Accessibility and Support Services
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Email to SASS