STUDENT INTAKE INFORMATION - DISABILITY SUPPORT SERVICES

128 ECC STONY BROOK, NY 11794-2662 PH # 631-632-6748 FAX 631-632-6747

Date:________________
Name:___________________________________SB#:____________________________

Address:____City:_______________

Zip:_______Campus Add:________________________________Tel:_______________

DOB:______________Major:__________________E-Mail:_______________________

Transfer:Y___N___ Year: Fr / So / Jr / Sr / Gr GPA_______ Full-time:Y___N___

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:
Name:____________________Relationship:_____________Phone #:______________

Services Requested:____

__ Letters to Faculty
__ Extended Test Time
__ Books on Tape
__Notetaker/Scribe
__Assistive Devices
__Equipment Loan
__ Accessibility
__ Disability Housing
__Interpreters
__ Para-transportation
__ Other

AGENCY: VESID_____ CBVH_____ AIM/EOP_____ SSI/SSD_____
Counselor's Name:___________________________Tel:__________________________

DISABILITY:

____

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? Y / N
Describe:____

ARE YOU TAKING ANY MEDS (PRESCRIPTION, OVER THE COUNTER, HERBAL SUPPLEMENTS, VITAMINS, OR RECREATIONAL DRUGS)? If so, please list:_______________________________________
____

New York State Voter Registration - Would you like to register to vote today? DSS is an approved National Voter Registration Act location and can provide you with NYS voter registration forms and assistance in completing and submitting them. To register right now go to the following link and click need a voter registration form: http://www.elections.state.ny.us/.

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Please note that documentation of a disability must be on file with this office. All documentation is kept at DSS and is not a part of your academic record.

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DSS OFFICE INFO (DO NOT WRITE BELOW THIS LINE) JH DM PP
Documentation on file: YES____ NO, Requested____ / Date Received _________
Contact was made: In Person_________ By Telephone_________ By Mail_________
DC___________ ___________ Circle Request: Pending, Accepted
AC___________ ___________ Accom: Consider, Approved

Disability Support Services
www.**stonybrook**.edu/**dss**

128 ECC Stony Brook NY 11794-2662
(631)-632-6748 Fax (631) 632-6747
DSS@NOTES.CC.SUNYSB.EDU

Documentation of Disability Form

Student's Name: ______________________________Student DOB:________________________

SBID#__________________Telephone____________________________

Disability Support Services complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services and activities. Please complete the form below to assist D.S.S. in determining appropriate and reasonable disability accommodations. Additional documentation may be required.

To be completed by the student's treating provider, NOT by a family member.
Please answer all questions that apply to the particular disability. Please print legibly.

Complete Diagnosis: ________________________
____
____

Date of Diagnosis: ________________________

Date of last visit for this condition: ______________

Procedures/assessments used to diagnose this student's condition (**ATTACH COPIES of assessment results used in making/confirming diagnosis**): ______________
____
____
____

Severity of the condition: Temporary Mild Moderate Severe

Student is compliant with medical treatment for this condition: Rarely Sometimes Often Unknown

Does this student take prescription medication for this condition? Yes No If yes, which medications? Please note any side effects: ________________________
____
________________________ Epi-Pen? Yes No

Describe how this condition substantially limits a major life activity. ("basic activities that the average person in the general population can perform with little or no difficulty.")
____
____
____
____

Affix business card or apply business stamp within this box

With what frequency does this student experience the limitation(s)? Rarely Occasionally Frequently

How will the limitation(s) interfere with this student's ability to participate in student life (e.g., academics, recreation, etc.)?
____
____
____
____

Describe any substantial equipment prescribed for this student's home or school environment: ______________
____
____
____

Recommended accommodation (must be clearly linked to functional limitations): ______________________
____
____
____

List all hospitalizations related to the disability__________
____
____
____

Provider's Signature: ________________________

Physician's Name: ________________________
Address: ________________________
____
License/Cert. #: ______________**State:** ________
Specialty: ________________________
Phone: ______________ **Fax:** ______________