**DISABILITY DOCUMENTATION FORM**

Accessibility Services at New York Film Academy provides services and/or accommodations for students with disabilities intended to facilitate equal access to educational opportunities. To determine eligibility for services and/or accommodations, current and comprehensive documentation regarding a physical or mental condition and its impact on the student’s function is required from a licensed medical professional qualified to diagnose and treat the particular condition(s).

**I request that this form be completed and returned, along with any supporting documentation regarding my condition, to Student Accessibility Services.**

Student signature Date

**Please complete the following:** (to be completed by physician)

Name of Student Date of Birth

Date of Diagnosis Date of Last Contact

Diagnosis

**What sources were used to obtain that verified diagnosis? Check all that apply:**

* History of presenting symptoms
* Academic history of elementary, secondary, tertiary education. Attach any supporting documentation, e.g. Individualized Education Plan (IEP), 504 plan, Multi-Factored Evaluation (MFE), teacher reports, etc.
* Family History: Prevalence in the family of same or other relater diagnosis.
* History of previous therapy including history that is relevant to the current diagnosis.
* Psychometric Instruments (please specify)

Date of testing:

**What is the anticipated duration of the impacting symptom? (Circle one)**

6 months 1 year More than 1 year

**Major Life Activities Impacted**: Below is a checklist of the major life activities that could be impacted by the stated diagnosis. Please check all that apply.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Major Life Activity** | **No Impact** | **Mild Impact** | **Moderate Impact** | **Substantial Impact** |
| Caring for one’s self |  |  |  |  |
| Eating |  |  |  |  |
| Sleeping |  |  |  |  |
| Concentrating |  |  |  |  |
| Memorizing |  |  |  |  |
| Managing internal distractions |  |  |  |  |
| Managing external distractions |  |  |  |  |
| Social interactions |  |  |  |  |
| Organizing |  |  |  |  |
| Managing stress |  |  |  |  |
| Regular and timely attendance |  |  |  |  |
| Making and keeping appointments |  |  |  |  |
| Maintaining deadlines |  |  |  |  |
| Talking |  |  |  |  |
| Hearing |  |  |  |  |
| Breathing |  |  |  |  |
| Lifting |  |  |  |  |
| Learning |  |  |  |  |
| Thinking |  |  |  |  |
| Interacting with others |  |  |  |  |
| Listening |  |  |  |  |
| Speaking |  |  |  |  |
| Seeing |  |  |  |  |
| Reading |  |  |  |  |
| Standing |  |  |  |  |
| Reaching/Grasping |  |  |  |  |
| Sitting |  |  |  |  |
| Light Exercise |  |  |  |  |
| Moderate Exercise |  |  |  |  |
| Rigorous Exercise |  |  |  |  |
| Walking |  |  |  |  |
| Writing |  |  |  |  |
| Performing manual tasks |  |  |  |  |

How else might the student’s disability impact their academic performance?

How else might the student’s disability impact on getting around campus?

Please list any side effects of current medication that might affect the student’s academic performance:

What are you recommendations for reasonable accommodations?

**HEALTHCARE PROVIDER INFORMATION**

|  |
| --- |
| The information I have provided is accurate to the best of my knowledge and the condition for which I treat the student is within the scope of my professional licensure or certification  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name, Title, Credentials:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please return this form to: New York Film Academy, Dean of Students**

17 Battery Place, Room 101

New York, NY 10004

Ph. 212.674.4300 ext. 294 Fax. 212.966.4534

Deanof students@nyfa.edu