Medical Provider Statement/Diagnosis

Student Name (Last, First): ______________________________

DOB: ______________

For the Medical Professional

The student named above has applied for services provided by the Office of Accessibility Services at John Jay College. Their application cites a disability or medical condition that may interfere with performance in course work or other aspects of college life. In order for appropriate services to be provided, your assistance is requested. Please specify any functional limitations or restrictions that may exist, which are the result of this student's disability, medical condition, or medical regimen. Please be as specific as possible in your indications.

We appreciate your cooperation and prompt response in helping us to provide appropriate accommodations in compliance with the Americans with Disabilities Act.

Provider Information

Physician Name: ______________________________

Address: ______________________________ Suite/Floor: __________

Phone: ______________ Fax: ______________

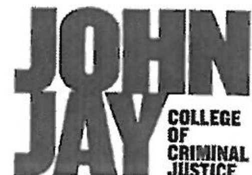
Email: ______________________________

Signature: ______________________________ Date: __________

State Licensure/Number (Required for Processing Authentication)

Physician's License #: ______________________________

Stamp:



Diagnostic Information

Please specify diagnosis:

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Diagnosis Onset Date: ____________________________

Current Evaluation/Visit Date: _______________________

Please specify: ☐ chronic illness ☐ temporary illness ☐ permanent condition

Please specify and describe functional diagnostic limitations:

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Please specify current medications and side effects:

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Please specify and list academic accommodations necessary for academic success:

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