Stony Brook University
Student Health, Wellness and Prevention Services

Student Accessibility Support Center (SASC)
Stony Brook Union Suite 107
(P) 631-632-6748
(F) 631-632-6747
sasc@stonybrook.edu
stonybrook.edu/sasc

Stony Brook University complies with federal and state disability laws requiring that universities ensure equal access to educational programs, services, and activities for qualified persons with disabilities. To assist SASC in determining appropriate and reasonable disability accommodations; please complete the attached form. Please know that additional documentation may be required.

Please take note of the following as you complete this form:

A. The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition. Examples include psychiatrist, psychologist, therapist, social worker, medical doctor, nurse practitioner, optometrist, speech-language pathologist.

B. Please complete all parts of this form as thoroughly as possible. **Inadequate information, illegible handwriting, or missing fields may delay the review process** and necessitate follow up contact for clarification.

C. Please attach any other documents or information you think would be relevant in determining the student's academic accommodations.

Once completed, please return this form back to the student so that they may deliver it along with their Student Intake to SASC.
If you have questions regarding this form, please call SASC at 631-632-6748.

Thank you for your assistance.
Student Accessibility Support Center
Stony Brook Union Suite 107
Stony Brook University
Stony Brook, NY 11794-3216
Voice: 631-6326748
Fax: 631-632-6747
SASC@stonybrook.edu

By signing below, you indicate that you have read the above guidelines, and agree to complete the attached form accordingly.

Signature		**Date**	

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Documentation for Housing Accommodation Requests

Section 1: To Be Completed By Student

Student Information			
Preferred Name:		Pronouns:	
Student ID#		DOB:	
SBU Email:		Telephone:	

Section 2: To Be Completed By Provider

Diagnosis	
Complete Diagnosis:	
Date of Diagnosis:	Date of Last Visit:
Procedures/ Assessments Used:	
Severity of the Condition: Temporary☐ Mild☐ Moderate☐ Severe ☐	
Please state the medication or treatment currently prescribed: Side Effects Experienced:	

Disability and Accommodations	
Describe how this condition substantially limits a major life activity	
How will the limitations interfere with this student's ability to participate in residential life?	
List all hospitalizations related to the disability	

Please state recommended accommodation (must be clearly linked to functional limitations)	
***Single Room Request (please skip if student is not requesting a single room)**	
Explain how symptoms functionally prohibit student from living with a roommate	
Is it your professional opinion that an accommodation of a single room is essential for the students' physical/ mental health; even though this may increase isolation?:	

Provider Information	
Name:	
License/Cert #:	State:
Address:	
Specialty:	
Phone:	Fax:

Affix business card or apply business stamp within this box

Provider, please sign your name below.
By doing so, you are certifying that you are the person listed as completing this form, and you verify that you are not related to the student.
You also confirm that all information you have provided is accurate.

Signature		**Date**	