Cornell University
Student Disability Services

Cornell Health, Level 5
110 Ho Plaza
Ithaca, New York 14853
Phone: 607-254-4545
Fax: 607-255-1562

Medical Documentation of a Physical or Chronic Medical Disability

(Do NOT use for Learning Disabilities, ADD/ADHD, Psychological, or other cognitive disorders)

Student Disability Services (SDS) provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. Federal disability laws define a disability as an impairment that substantially limits one or more major life activities, such as walking, seeing, hearing, speaking, breathing, eating, caring for one's self, performing manual tasks, and working. Current and comprehensive documentation from a health care provider (who is not a family member) is required to assist with the determination of eligibility for disability services and the provision of appropriate and reasonable accommodations and/or auxiliary aids. All decisions regarding appropriate disability services and accommodations to achieve equal access will be made by SDS. SDS appreciates the input of medical experts on the access needs of the student in post-secondary education. Additional documentation may be requested.

To be completed by the student's certified health care professional.
All items are required. Please print legibly. Include additional pages, if needed.

Physician's Name: _____ Today's Date: _____
Address: _____
License/Cert: #: _____ Phone: _____ Fax: _____

Student's Name: _____ DOB: _____
Diagnosis: _____
Date of Dx: _____ Severity of condition (circle one): Mild Moderate Severe In Remission
Please describe the symptoms of this disability, when in an active state, including frequency and duration, if applicable: ___
_____
_____
_____
Treatment and/or medications currently being used: _____
_____
Functional limitation(s)/impact caused by this disability, or its treatment, on daily living for this student: _____
_____
_____
_____
Recommendations for disability management within the post-secondary school setting (must be clearly linked to functional limitations/impact): _____
_____
_____
Anticipated Prognosis and medical follow up: _____
Physician/Health Care Provider Signature: _____

I, _____, authorize my health-care provider above to release to SDS the medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Cornell University.
Signature of patient: _____ CU ID Number: _____ Date: _____
If signed by person other than patient, state relationship and authority to do so.
Relationship: _____ Legal Authority: _____