BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Services for Students with Disabilities
UU119

PO Box 6000
Binghamton, New York 13902-6000
607-777-2686 Voice, Fax: 607-777-6893
Email: ssd@binghamton.edu

Autism Provider Form

Students with documented long-term or permanent disabilities or serious medical conditions may qualify for equal access accommodations. In lieu of documentation of diagnostic testing, students may submit this form in order to establish eligibility with an Autism diagnosis.

This form must be submitted by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title, and license or certification credentials must be stated in the documentation, dated, signed and specifically addressed to SSD. Forms completed by relatives will not be accepted.

Forms may be completed electronically, but must include either an ***original signature*** *or* ***office stamp*** *to be authenticated.* ***FORMS WITHOUT THESE WILL NOT BE REVIEWED.***

Student Information

Student's Legal Name: ______________________________

Student's Preferred Name and Pronouns: ______________________________

Student's Date of Birth: ______________________________

Provider/Student Relationship

1. How long have you been working with the student? ______________________________

2. When did you last see the student? ______________________________

Diagnostic Information

3. Does the student have a confirmed diagnosis of Autism? ☐YES ☐NO
4. Were you the provider who diagnosed the student with Autism? ☐YES ☐NO

   If No, can you confirm the student's Autism diagnosis? ☐YES ☐NO

5. Does the student have any additional diagnoses? ☐YES ☐NO ☐UNKNOWN

   If yes, please list below:

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6. How was the diagnosis of Autism determined and when? Please indicate if testing was a comprehensive psychological evaluation, ADOS-II, or derived in any other means.

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7. Please describe the functional impact experienced by the student in relation to their Autism diagnosis as it pertains to an **academic setting** (e.g., impact on studying, test taking, note-taking).

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8. Please describe the functional impact experienced by the student in relation to their Autism diagnosis as it pertains to **daily living** (e.g. eating, sleeping, transportation, recreation).

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9. Please describe all current treatments and management strategies (e.g., medication, stress-reduction, resources, coping strategies, on-going therapeutic services).

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10. If there is any other pertinent information you would like to share with SSD staff, please list below.

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Please complete the Provider's Contact Information below, and return it to:

Services for Students with Disabilities -UU119
Binghamton University
P.O. Box 6000
Binghamton, NY 13902
Phone: 607-777-2686
Fax: 607-777-6893
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Provider's Contact Information:

Name and credentials: ____

Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): ________________

Address: ____

Fax and/or email address: ______________________________________

Telephone Number: ____

Professional Signature: ____

License Number and State: _____________________________________

Date: ____