



NYIT Office of Accessibility Services

Clinician Verification

To be completed by the appropriate treating clinician

Student Name: _____ Date: _____

The student named above seeks to register with the Office of Accessibility Services (OAS) at New York Institute of Technology. In determining eligibility for accommodations, the OAS requires verification of a disabling condition pursuant to the Americans with Disabilities Act.

1) Diagnosis/Description of the condition which necessitates accommodations (please include ICD-10 or DSM-V code(s)):

2) Symptoms/Manifestations:

3) Does this condition substantially limit the ability to perform a major life activity? If yes, what activities are impacted?

4) Approximate date the diagnosis was established: _____

5) Current treatment approach (including ongoing therapies, prescribed medications and PRN interventions):

6) The noted condition is:

- Permanent/Chronic
- Long term: 6-12 months
- Short term/Temporary: 6 months or less



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7) Please indicate the accommodation(s) you recommend:

Test-Specific Accommodations:

- 1.5x Extended Time
- 2x Extended Time
- Distraction-Reduced Testing Location
- Use of a Laptop
- Magnified Text
- Breaks (Approx. every _____ minutes)
- Reader
- Scribe
- Alternative to Scantrons
- Calculator

Classroom/Academic Accommodations:

- Preferential Seating
- Permission to Audio-Record Class
- Use of Assistive Listening Devices
- Attendance and Deadline Flexibility
- Breaks (Approx. every _____ minutes)
- ASL Interpreter
- CART Services
- Note-Taker

Other Accommodations:

- Preferential Housing Arrangements
- Wheelchair/Scooter Accessibility
- Priority Registration
- Dietary Needs

8) Please use this space (and additional pages if needed) to recommend any other accommodations, and/or to provide further information about the student’s disabling condition to aid the OAS in understanding the student’s needs. You may wish to note the severity of the condition, how critical accommodations are to the student’s health, safety and success, etc.:



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Certifying Professional:

Signature: _____ Date: _____

Name (Please Print): _____

Title: _____

Name of Agency: _____

Street Address: _____

City/State/Zip: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

All documentation submitted for consideration to the NYIT OAS is confidential. When submitting documentation, please include a copy of any available releases allowing communication between the OAS and the diagnostician.

Documentation should be sent to:

NYIT Accessibility Services
P.O. Box 8000
Old Westbury, NY 11568
Fax: (516) 686 – 7891
E-Mail: accessibility@nyit.edu
Phone: (516) 686 – 4934

All recommendations are considered, but not all can be guaranteed. Decisions are made based on the nature of the disability, reasonableness of the request, and academic integrity.