



Center for Accessibility and Inclusive Education  
P.O. Box 3300 \* Somerville, NJ 08876  
Phone: (908) 526-1200 ext.8534  
Fax: (908) 526-3494  
[caie@raritanval.edu](mailto:caie@raritanval.edu)

## Chronic Medical Disability Documentation Form

Please complete this form with as much detail as possible, as a partially completed form or limited responses may hinder the eligibility process. It is most important that you thoroughly explain any symptoms and indicate their impact on functioning. If you wish to provide additional information, please attach it to these forms.

*Thank you for your assistance.*

### To be completed by the treating, licensed healthcare professional only

Student's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of initial contact with student: \_\_\_\_\_

Date student was last seen: \_\_\_\_\_

Frequency of appointments: \_\_\_\_\_

### What is the Student's Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

How long has the student had this diagnosis/condition: \_\_\_\_\_

What is the severity of the condition(s):

Mild

Moderate

Severe

What is the expected duration:

Chronic (more than a year)

Episodic

Short-term (six months- one year)

Please explain severity and duration: \_\_\_\_\_



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Provide information regarding the student's current symptoms and functional limitation that you feel are relevant to the academic setting:

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Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for reasonable accommodations that you believe will help equalize the student's ability to access the RVCC educational program along with rationale for each:

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Additional information you believe would be helpful in determining the nature and severity of this student's disability, and any additional recommendations that may assist the CAIE in determining appropriate accommodations:

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List the student's current medications(s), including dosage, frequency, and adverse side effects (if applicable) :

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Are there significant limitations to the student's functioning directly related to the prescribed medications?

Yes No if yes, explain: \_\_\_\_\_

### Certifying Professional

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Area of Specialty

\_\_\_\_\_  
License Number

\_\_\_\_\_  
State Licensure

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Signature of Certifying Professional

\_\_\_\_\_  
Date

**Please Return to:**  
**Center for Accessibility and Inclusive Education (CAIE)**  
**Raritan Valley Community College**  
**College Center C-124**  
**Fax (908) 526-3494**  
**[caie@raritanval.edu](mailto:caie@raritanval.edu)**