RARITAN VALLEY COMMUNITY COLLEGE

Disability Services
P.O. Box 3300 * Somerville, NJ 08876
Phone: (908) 526-1200 ext. 8534
Fax (908) 526-3494
disabilityservices2@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 licensed, treating healthcare professional only

Student's name: _____

Today's date: _____

What is the student's diagnosis? _____

How long has the student has this diagnosis/condition? _____

Date of initial contact with student: _____ Date student was last seen: _____

Frequency of appointments _____

What is the severity of the condition? ☐ 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: _____

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

_____

_____

_____

List the student's current medication(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: _____

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's educational program along with rationale for each):

_____

_____

_____

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 DS in determining appropriate accommodations:

_____

_____

Certifying Professional

_____ Name and Title

_____ Area of Specialty

_____ License Number

_____ State of Licensure

_____ Address

_____ Phone Number

_____ City, State, Zip

_____ Fax Number

_____ Signature of Certifying Professional

_____ Date

Please return to:
Disability Services - Raritan Valley Community College
College Center C-124
Fax (908) 526-3494
disabilityservices2@raritanval.edu