REQUEST FOR DISABILITY RELATED HOUSING ACCOMMODATIONS

- Students seeking specific housing consideration due to disability or medical necessity must complete and sign the **STUDENT INFORMATION** and **AUTHORIZATION TO RECEIVE HEALTH CARE INFORMATION** sections below.
- In order to effectively evaluate how Medaille College can best meet a student's need for medical housing consideration, the College requires specific diagnostic information from a licensed medical professional or health care provider. The provider should be familiar with the history and functional limitations of the student's physical or psychological condition(s). The provider must complete and sign the **MEDICAL / HEALTH CARE PROVIDER** sections on pages 2 and 3 of this form. *The provider cannot be a relative of the student requesting disability-related housing accommodation.*
- **Emotional support animal requests (ESA)** please have healthcare provider complete Section I of this form and refer to the policy for additional documentation needed.
- **All other disability-related housing accommodations** please have medical provider complete Section II**.**
- The student's signature on this form constitutes permission for the appropriate and qualified Medaille College staff member(s) to speak with the provider who completes this form. This request is valid for the current academic year only and must be re-submitted each academic year.

STUDENT INFORMATION

Name:_____ Student ID# _____
Last First Middle

Email Address:_____@medaille.edu Gender:_____ DOB: _____
mm/dd/yyyy

Home Address: _____
Street City State Zip Code

Local Address: _____
Street City State Zip Code

Home Phone:_____ Cell Phone: _____

Type of Request:_____ Specific Room Type or Location _____ Off-Campus Housing (*Request to Terminate Room and Board Agreement* form also required) _____ Room or Residence Hall Fixtures, Equipment, etc.

_____ Other (please specify): _____

AUTHORIZATION TO RECEIVE HEALTH CARE INFORMATION

I authorize Medaille College to receive information from the provider below. Furthermore, I authorize my provider to discuss my condition(s) with the appropriate and qualified Medaille College personnel on an as needed basis.

Provider Name:_____ Provider Specialty: _____

Address:_____ Phone: _____
Street City State Zip Code

Student's Signature:_____ Date: _____

Parent/Legal Guardian signature is required if the student is under 18 years of age:

Parent/Legal Guardian Signature: _____

OPTIONAL: I authorize Medaille College to exchange applicable information with the following person on my behalf: _____

Address: _____

Relationship to student: _____ Phone: _____

Student's signature: _____ Date: _____

TO BE COMPLETED BY MEDICAL / HEALTH CARE PROVIDER

SECTION I. To be completed by health care professional ONLY if requesting an EMOTIONAL SUPPORT ANIMAL.

1) Does the student who you have individually examined and treated have a physical or mental impairment that substantially limits one or more major life activities?

2) If yes, describe what major life activities are impaired: Identify the disability-related need for an ESA, and explain how the animal alleviates one or more of the identified substantially-limiting major life activities (thereby reducing the identified symptoms or effects of this individual's existing disability).

3) What type of animal is being requested?

SECTION II. To be completed by a health care professional for all non-ESA disability-related housing accommodation requests.

To determine eligibility for disability-related housing, Medaille College requires current and comprehensive documentation of the student's condition(s) from a licensed medical professional or health care provider familiar with the history and functional limitations of the student's condition(s). The provider completing this form cannot be related to the student.

Items 1 – 5 must be completed in full and be legible. If more space is needed, please attach a separate sheet of paper. Reports which provide additional information may also be attached.

1) What is the student's diagnosis and how does it impact them in a college residential living environment?

_____

_____

_____

a) How long has the student had the condition(s)? _____

_____

_____

b) What is the severity of the condition(s)? _____

_____

_____

c) How long is the condition(s) likely to persist? _____

_____

_____

2) Why is a medical single or off-campus living a medical **necessity or requirement** for participation in college? If the student were to not have this consideration would the student still be able to attend college?: _____

_____

_____

_____

_____

3) Please list the student's current medication(s), dosage, frequency, and adverse side effects: _____

_____

_____

_____

_____

_____

4) Are there any significant limitations to the student's functioning directly related to the prescribed Medication (s)?_____If yes, please explain: _____

_____

_____

_____

5) Please state specific recommendations regarding housing, and a rationale as to why these housing needs are warranted. Indicate why the change(s) to the student's housing are necessary (e.g., if a single room or living off-campus is suggested, state the reasons related to the student's condition for the request): _____

_____

_____

_____

a) Which, if any, of the following are medically necessary? Check all that apply.

- ☐ Off-Campus Housing
- ☐ Specific Room Type or Location (please specify): _____
- ☐ Room or Residence Hall Fixtures, Equipment (please specify): _____
- ☐ Other (please specify): _____

6) If current treatments/medications are successful, please state why the above housing changes are necessary:

_____

_____

_____

MEDICAL/HEALTH CARE PROVIDER INFORMATION

THIS SECTION MUST BE COMPLETED, SIGNED OR STAMPED WITH PROVIDER'S OFFICE INFORMATION

The provider completing this form cannot be related to the student

Provider Name/Title (please print): _____

Address: _____

Phone Number: _____

Provider's Signature: _____ Date: _____

License Number: _____ State: _____