Housing and Residence Life Accommodation Request

Requestor's Name_____

(*The following is to be filled out by your Treating Physician or Counselor)*

1. How long have you been treating this individual?
   _____
2. Describe the housing accommodation you feel will best help this student?
   _____
   _____
3. In your professional opinion, how is the accommodation necessary to alleviate the identified symptoms of the student's documented disability?_____
   _____
   _____
4. What disability-related symptoms will be reduced by this accommodation?_____
   _____
   _____
5. What do you anticipate the impact would be, in terms of disability symptomology, which may result if the accommodation is not approved?
   _____
   _____
   _____
6. Is there a different accommodation that could be provided to mitigate the impact of the student's disability? If so, please explain._____
   _____
   _____

Physician/Counselor Name_____

License Number_____

Physician/Counselor Signature_____