Request for Housing Accommodations

TO THE STUDENT: Please complete and sign the authorization to receive disability-related information noted below. Your signature authorizes the Office of Student Disability Services to request an authorized health professional to complete the information requested herein and to speak to this health professional, if necessary.

TO THE HEALTH PROFESSIONAL: In compliance with federal ADA regulations for housing accommodations, the University of the Incarnate Word (UIW) requires specific diagnostic information from a licensed health professional who is **not related** to the student. This health professional should be familiar with the history and functional limitations of the student's disability. Please fill out pages 2 and 3, sign, date and return the completed form to this address:

Student Disability Services
University of the Incarnate Word
4301 Broadway, CPO #286
San Antonio, TX 78209
Phone: (210) 829-3997
Fax: 210-829-6078

DEADLINES: Undergraduate and graduate students who are seeking housing accommodations are required to submit their requests on or before the following deadlines:

- March 1st if you are a returning student for the fall semester
- June 1st if you are an incoming student for the fall semester
- September 1st if you are applying for housing for the spring semester
- Requests to modify a meal plan due to food allergy must be submitted no later than the last day to drop classes at 100% refund rate (as posted on the Academic Calendar)

NOTE: Submitting a request for housing accommodation does not eliminate the requirement for a student to complete a housing application with the Residence Life Office.

STUDENT: Please fill out this section. Print Clearly or Type

Student Name: _____ Student ID # _____

Address: _____

_____

Cardinal email:_____

Daytime phone: _____

Authorization to Receive Disability-Related Information

I authorize the Office of Student Disability Services of the University of the Incarnate Word to receive information from the licensed health professional noted below. I also authorize this licensed health professional to discuss my disability with the Office of Student Disability Services staff, upon request.

Name of Licensed Health Professional:_____

Relationship to Student: _____

Address: _____ Phone: _____

Student signature: _____ Date:_____

CERTIFYING LICENSED HEALTH PROFESSIONAL: Please complete this section. Print Clearly or Type

Please complete **Items 1 thru 5.** If the space provided is not adequate, please attach a separate sheet. You may also attach a report providing additional related information.

Please respond to the following items regarding the student named above:

1) What is the student's disability/diagnosis: _____

_____

_____

   a. How long has the student had this disability? _____

   b. What is the severity of the disability? _____

   _____

   c. How long is this disability likely to persist? _____

2) Describe the symptoms related to the student's disability that cause **significant impairment** in a major life activity:

_____

_____

_____

_____

_____

_____

3) List this student's current medication(s), dosage, frequency, and adverse side effects:

_____

_____

_____

   a. Are there any significant limitations to the student's functioning directly related to the prescribed medications? _____ Yes _____ No

If yes, please explain: _____

_____

_____

Please state specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the housing accommodation(s) you recommend are necessary. **(NOTE: Private rooms are subject to availability and are not granted as accommodations for ADHD and Learning Disabilities.)**

_____

_____

_____

_____

_____

4) If current treatments (i.e., medications, etc.) are successful, why are the above accommodation recommendations necessary?

_____

_____

_____

_____

NOTE: The licensed health professional completing this form cannot be a relative of the student

Signature of Licensed Professional: _____ Date: _____

License #: _____ State: _____

(Please Print) Name/Title: _____

Address: _____

_____
City State Zip

Phone: _____ Fax: _____

The licensed health professional completing this form may also send a report that provides additional and/or complementary information.