**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical/Health Care Provider Completes This Form – Please print or type**

To determine eligibility for changes to the housing environment, Emory University’s Access, Disability Services and Resources requires current and comprehensive documentation of the student’s condition from a licensed clinical professional or health care provider familiar with the history and functional limitations of the student’s condition(s). Please corroborate the need for the housing accommodations requested by this student (i.e. Housing Accommodation Request Form). Include why the change(s) to the housing environment you recommend are necessary. For example, if you suggest a private bathroom, state the reasons for this request related to the student’s functional limitations and disability. The provider completing this form cannot be a relative of the student. All items must be completed in full. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

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

1. What is the student’s medical condition/diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Level of severity: \_\_\_Mild \_\_\_Moderate \_\_\_ Severe
   2. Duration: \_\_\_ Temporary \_\_\_Permanent \_\_\_Chronic/Recurring \_\_\_ Episodic
   3. Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. Date of initial contact with student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   5. Most recent contact with student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe the symptoms related to the student’s condition that cause significant impairment in a major life activity

1. **Major Life Activities Assessment:**

Please check which of the following major life activities listed below are affected because of the impairment. Please indicate the severity of the limitations.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Life Activity** | **Negligible** | **Moderate** | **Substantial** | **Not Applicable** |
| Talking |  |  |  |  |
| Hearing |  |  |  |  |
| Breathing |  |  |  |  |
| Standing |  |  |  |  |
| Caring for Oneself |  |  |  |  |
| Reaching |  |  |  |  |
| Lifting |  |  |  |  |
| Sitting |  |  |  |  |
| Walking |  |  |  |  |
| Seeing |  |  |  |  |
| Writing |  |  |  |  |
| Performing Manual Tasks |  |  |  |  |
| Sleeping |  |  |  |  |
| Learning |  |  |  |  |
| Reading |  |  |  |  |
| Thinking |  |  |  |  |
| Concentrating |  |  |  |  |
| Memorizing |  |  |  |  |
| Interacting with Others |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

1. Describe the functional limitations of the student’s condition as they may relate to campus housing.

1. How will the student manage these symptoms in other campus environments (e.g. dining hall, library, computer labs, classrooms)?

1. For episodic conditions, how frequent are the episodes, and what is their duration?

1. List the student’s current medication(s), dosage, frequency and adverse side effects (if applicable).

1. Are there any significant limitations to the student’s functioning directly related to the prescribed medications? \_\_\_ Yes \_\_\_ NO If yes, please describe:

1. Is the requested accommodation(s) \_\_\_\_ medically necessary or \_\_\_ medically beneficial (Check one.) Please explain response:

1. Describe possible alternatives that could be considered if the preferred accommodation is not available.

**The provider may also send a report that provides additional relevant information.**

**The provider completing this form cannot be a relative of the student.**

Signature of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

License#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_

Please Print

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_