



Student Disability/Medical Request Form for Special Housing Accommodations

Student Name: _____ Date: _____
Telephone/TTY: _____ R #: _____
On Campus Address: _____
Permanent Address: _____

1) In 1-2 sentences, please indicate the housing accommodations you are requesting (ex. single room, air-conditioned room, etc.) _____

2) Please type a personal statement identifying your rationale for the requested accommodations. Be specific regarding all circumstances relevant to your request. Attach the statement to this form.

Before turning in the request for housing accommodations on the basis of disability please initial each statement and sign at the bottom:

_____ I understand that by turning in this request for accommodations, I am claiming to have a **disability** as defined by the Americans with Disabilities Act or a medical necessity. A disability is a physical or mental impairment that substantially limits a major life activity in comparison to the average person. If I am not claiming to have a disability, I need to contact the Office of Residence Life for further instructions. Disability Services only serves students with disabilities.

_____ I understand the role of the Office of Accessibility is to determine if my condition constitutes a disability. If my condition does not meet the definition of disability, my housing request will be returned to me and I will assume responsibility for following up with the Office of Residence Life.

_____ I understand that this process will take up to four (4) weeks after the receipt of the completed request by the Office of Accessibility. The only exception is in the case of an emergency or medical change. In this instance, information from a doctor documenting the urgency of the matter will be required.

_____ I understand that I will be notified in writing from the Office of Residence Life regarding the status of my request and that the Office of Accessibility will not give information over the phone other than verification of the receipt of the request.

_____ I understand that if my request is not complete when submitted it will be denied.

A complete request consists of:

- The request form
- The typed personal statement
- The typed and signed documentation from your medical professional (doctor, psychologist, etc.)

I understand all of the afore-mentioned statements.

Signature

Date



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I, _____, a student at the University of Toledo give permission to release the requested information to the Office of Accessibility at the University of Toledo.

Signature Date

This section is a guide for doctors to follow when completing documentation. Physicians/Psychologists may use this form for convenience or make sure to include all of the information requested in a separate statement. If using this form, please type responses. Illegible forms will be returned to the student. We need as many details as possible in order to determine the presence of a disability or medical need; please take the time to be specific and clear.

The University of Toledo has a residence hall system with varying environments and environmental controls available to meet resident needs. If the student has a disability/medical need that cannot be accommodated within a living unit on campus, the residency requirement will be amended. Please note that as you respond to the following questions, frame your responses to identify environmental changes that will alleviate the student's symptoms, the current and recommended treatment, and specific causes and symptoms of the student's condition.

Please indicate the nature of condition: **Medical Diagnosis** **Disability Diagnosis** (As defined under ADA)

Other Diagnosis: _____ **Date of Diagnosis:** _____ **Last Contact:** _____

Basis on which diagnosis was made: _____

DSM-IV Diagnosis: Axis I: _____ Axis II: _____ Axis III: _____ Axis IV: _____ Axis V: _____	OR	ICD Diagnosis: _____ _____ _____ _____
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Please list the symptoms and severity of the student's condition. Please be specific.

Please list the causes of the symptoms. Please be specific.



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What specific environmental changes will alleviate the student's symptoms?

Current medications including dosage and side effects experienced by the individual:

Long-term medication plan:

Current adherence to medication plan:

Prognosis (include likelihood of improvement or further deterioration and within what approximate time frame):

Qualified Professional's Name & Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

License/Certification Number _____

State of Licenser: _____

Type of License: _____

Date of Initial Contact with Student: _____

Last Date of Contact with Student: _____