Verification Form for Students Requesting Changes to the Housing Environment Due to a Significant Chronic Physical or Emotional Condition

In order to evaluate how The University of Scranton can best meet a student's need for special housing request, the University requires specific diagnostic information from a licensed clinical professional or health care provider who is familiar with the history and functional limitations of the student's physical or psychological condition(s). The student must complete page one of the form below. Also, to facilitate the process, the University requires the student to fill out and sign the Authorization to Receive Health Care Information below. This signature provides the appropriate and qualified University staff member permission to speak with the provider who completes the information on this form, and if the student desires, the permission to discuss the student's condition or resulting determination with a person of the student's choosing. The professional/provider must complete pages two and three, sign, and return the completed packet**. Date by which the University needs to receive requests to avoid a delay in providing an accommodation: January 31st – Upperclassmen and June 1st –Incoming Freshmen.**

Mail: The University of Scranton
Center for Teaching & Learning Excellence (CTLE)
800 Linden St.
Scranton, PA 18510

Fax: 570-941-4154

TO BE COMPLETED BY THE STUDENT – PLEASE PRINT OR TYPE.

Student Name: _____
(Last) (First) (Middle)

Student ID: _____ Email: _____

Birth Date: _____ Gender: Male _____ Female _____

Semester (s) Requesting Special Housing Accommodation: _____

Home Address: _____ Local Address: _____

_____ _____

Home Phone: _____ Cell Phone: _____

I authorize The University of Scranton to receive information from the provider below. I also authorize my provider to discuss my condition(s) with the appropriate and qualified University personnel on an as needed basis.

Name of Provider: _____

Address (Street, City, State, Zip): _____

(OPTIONAL) I authorize The University of Scranton to exchange applicable information with the following person(s) on my behalf:

Name: _____ Relationship to student: _____

Address and Phone: _____

Student's Signature: _____ Date: _____

Medical/Health Care Provider Completes and Signs Section Below:

STUDENT'S NAME: _____

Provider Completes the Section Below:

To determine eligibility for changes to the housing environment, The University of Scranton 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). The provider completing this form cannot be a relative of the student. **Items 1 thru 5 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? _____

_____

_____

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

_____

_____

b. What is the severity of the condition? _____

_____

_____

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

_____

_____

2. Describe the symptoms related to the student's condition that cause **substantial** impairment in a major life activity.

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

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

If yes, please describe:

_____

_____

_____

4. Please state specific recommendations to be considered by the University regarding housing, and a rationale as to why these housing needs are warranted based upon the student's medical (physical or emotional health) condition. Indicate why the change(s) to the housing environment you recommend are necessary (e.g. if you suggest the use of an air conditioner or private bathroom state the reasons for this request related to the student's condition).

_____

_____

_____

_____

5. If current treatment (e.g., medications) is successful, why are the above changes to the housing environment necessary?

_____

_____

_____

The provider may also send a report that provides additional related 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: _____