MONMOUTH UNIVERSITY | DISABILITY SERVICES *for* STUDENTS

Request for Housing Accommodations Provider Form

In order for a student's request for an accommodation in housing to be processed, a provider form must be completed by the student's treating healthcare professional. The Treating healthcare professional should answer all questions fully, include a signature and office stamp at the bottom of the form. Incomplete forms will not be accepted.

This form must be completed by a licensed professional.

You are being asked to provide documentation of a diagnosis for: _____
[Client/Patient Name]

Practitioner Name/Title: _____

_____

License or Certification number: _____

Specialty/qualification to make diagnosis: _____

Please place licensed healthcare professional's stamp.
If treating healthcare professional does not have a stamp, Submitting letterhead will be accepted in its place.
If left blank, form will not be accepted.

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

To be eligible for services, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Nature of disability with formal diagnosis. Please include expected duration.

Diagnosis	Date of Diagnosis	Date of last contact	Expected duration
Comments:			

2. Severity of condition: ☐ MILD ☐ MODERATE ☐ SEVERE
3. Check all relevant functional limitations that are substantially limited.

☐ Walking ☐ Hearing ☐ Seeing ☐ Working ☐ Sleeping ☐ Caring for self
☐ Interacting with others ☐ Learning (including memory/concentration)
☐ Performing manual tasks ☐ Other, please describe_____

_____

4. Please explain how each functional limitation will specifically affect your client/patient's ability to live in the residence halls.

5. List current medication(s), dosage, frequency and adverse side effects.

Medication	Dosage	Frequency	Side Effects:

6. **PLEASE SUGGEST REASONABLE HOUSING ACCOMMODATIONS**. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

7. Please state alternatives to meet the documented need if the first request cannot be met.

8. Please discuss the impact on your client/patient's disability if the accommodation cannot be granted.

9. How will the student manage these symptoms in other campus settings (i.e, classrooms, dining halls, libraries, etc.)?

Signature:_____ **Date:** _____

My signature verifies that I am the treating healthcare professional and that the contents of this form are accurate.

Email Form Print Form

Please note: Reasonable housing accommodations requests will be considered in consultation with the Department of Disability Services for Students, Office of Residential Life, or other offices as needed on a case-by-case basis.
At no time is a housing assignment guaranteed.

Please return the completed form and supplemental documentation in PDF format to:

Monmouth University
Department of Disability Services for Students (DDS)
400 Cedar Avenue
West Long Branch, New Jersey 07764
732-571-3460 ☎ 732-263-5126 🖷
dds@monmouth.edu