



Office of Health Services
MacClosky Townhouse Commons
515 Loudon Road
Loudonville, NY 12211
Telephone# 518-783-2554
Fax# 518-783-2961

SPECIAL HOUSING ACCOMODATION REQUEST FORM

Name		
SID#	Email Address	Cell Phone Number

Special housing requests are subject to recommendation by Health Services based on medical documentation and availability of accommodation. This Special Housing Accommodation Request Form is to be thoroughly completed and returned to the address at the end of this form as Health Services will not issue a recommendation without this documentation. Housing Services will make every attempt to accommodate housing preferences in conjunction with a reviewed special housing need by which Health Services recommends accommodation; however, the limited capacity of some areas and the number of students to be housed may dictate that you be assigned to an area you did not indicate as one of your preferences. Requests received after room assignments are issued may not be honored due to decreased availability.

This Form is to Be Completed by a Licensed Physician:

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

1. What is the student's medical condition/diagnosis, date of onset?

2. What is the severity of the condition?

3. How long is this condition likely to persist?

4. Describe the symptoms related to the student's condition that cause *significant impairment in a major life activity* which supports the request for special housing or other accommodations:

5. Describe the student's current treatment plan (including any medications or special diet):

6. Based on the student's current medical condition, please indicate the specific accommodation(s) you recommend:

7. Please provide comment as to how the accommodations requested will meet the student's functional needs based on the medical condition described:

The provider may also send a report that provides additional related information. The provider completing this form cannot be related to the student and must practice in the specialty area related to the condition identified.

Signature of Provider: _____ Date: _____

Address: _____

City: _____ State: _____

Affix Office Stamp Below

Telephone #: _____

Fax #: _____

OFFICE USE ONLY			
Request Reviewed: Date _____	Approved _____	Denied _____	Pending _____
By _____			
Student Notified: Date _____	By: E-Mail _____	Letter _____	
Residence Life Notified: Date _____	By: E-Mail _____	Letter _____	
Facilities Notified: Date _____	By: E-Mail _____	Letter _____	
Other: _____			

Please return this completed form to:

Health Services
MacClosky Townhouse Commons
515 Loudon Road, Loudonville, NY 12211-1462