APPLICATION FOR HOUSING ACCOMMODATIONS

MEDICAL PROFESSIONAL FORM

This documentation must be filled out by a licensed medical or mental health professional who has an established and ongoing relationship with the student.

This form is valid for one year from the signed date.

Student's Full Name: _____

Information About the Student's Disability:

Describe the history of the presenting problem and any current mental/medical health diagnosis(es): _____

_____

_____

Expected duration of the condition:

☐ Permanent ☐ Temporary ☐ Stable ☐ Progressive

Does the student require ongoing treatment? _____

Describe how the diagnosis listed above causes the student to be ***substantially limited*** to a major life activity (i.e. walking, breathing, seeing, hearing, learning, etc.). _____

_____

_____

_____

_____

When did you first meet with the student regarding this diagnosis, and in what context (that is, was it a face-to-face meeting or virtual interaction)? _____

_____

When did you last interact with the student regarding this mental health diagnosis? _____

_____

What ***specific*** symptoms will be reduced by having the requested housing accommodations, and ***how*** do you anticipate they will be relieved? _____

_____

_____

_____

In your opinion, how important is it to the student's well-being that they received the requested housing accommodation? What consequences, in terms of their disability symptoms, may result if the accommodation is not approved? _____

_____

_____

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The named student has signed this form (below) indicating written permission to share additional information with us in support of the request.

If you have any questions, please feel free to contact the Office of Accessibility & Accommodations by phone at 573-288-6000 ext. 6726 or by email accommodations@culver.edu.

Please provide contact information, sign and date below, and return the completed form via fax at 573-288-6547 or via email to accommodations@culver.edu.

Medical/Mental Health Provider's Contact Information:

Name: _____

Email: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical/Mental Health Professional's Licence Information:

Type of License: _____ Date: _____

State or other jurisdiction:_____ License #: _____

I certify, by my signature, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

PROFESSIONAL SIGNATURE: _____

DATE: _____