NAZARETH UNIVERSITY

Return Form
MAIL: Student Accessibility
Services
Nazareth University
4245 East Avenue
Rochester, NY 14618
EMAIL: sasoffice@naz.edu
FAX: 585-389-2499

On-Campus Special Housing Accommodation Request

PART I. To be completed by student requesting accommodations

Student Name: _____ Student ID: _____

Email Address: _____ DOB: _____ # of credits earned to date: ____

Current Campus Address: Building: _____ Room #: _____

Home Phone: _____ Cell Phone: _____

Current Academic Level: New Freshman☐ New Transfer☐ Returning Student☐

Which semester are you requesting accommodations: Fall☐ Spring☐ Summer☐

I am Requesting the Following Housing Accommodations: (Check all that apply due to disability)

Single room ☐	Ground floor room ☐
Modified room equipment for Deaf/Hard of Hearing ☐ Explain:	Medical Exemption from On-Campus Housing Requirement ☐ Explain:
Other ☐ Explain:	

1. I am requesting on-campus accommodations for the following reason(s):

Medical ☐ Psychiatric☐ Physical☐ Other (Explain): ☐_____

Provide a description of your condition: _____

_____

_____

_____

2. Explain how your request accommodates your condition: _____

_____

_____

_____

3. Indicate your understanding of the following conditions by reading and initialing each statement:

Housing Accommodations Process	**Initial**
Requests for on-campus housing accommodations must be submitted by: March 15th for Fall housing April 15th for Summer housing November 15th for Spring housing *Any requests submitted after the deadline will be considered as space permits!*	
A new form must be completed by the student and the Specialist **each year** special housing accommodations are requested.	
NEW students must fill out the general housing application form and pay their enrollment deposit found here	
Part 1 of the Special Housing Accommodation Request Form must be complete and contain the signature & date of the student making the request.	
Part 2 of the Special Housing Accommodation Request Form must be complete and contain the signature & date of medical/mental health professional completing the documentation of a disability. *Documentation from a family member or friend who is not the primary specialist is not accepted.*	
As part of the process, the medical provider who submits documentation may be contacted by the Special Housing Accommodations Committee in order to determine reasonable accommodations for the living environment.	
By submitting the Special Housing Accommodation Request Form, the student agrees that any information provided in conjunction with this request will be reviewed by the Special Housing Accommodations Committee and when necessary shared with relevant campus personnel (on a need-to-know basis). *The Nazareth University Special Housing Accommodations Committee will make the final determination in providing appropriate and reasonable accommodations.*	

Student Signature: _____ Date: _____

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PART II. To be completed by the diagnosing/treating specialist

Client/Patient Name: _____

To assist Nazareth University personnel in determining the need for housing accommodations for your patient, please complete the following information. Please be specific in your responses.

1. Are you the primary care physician or a specialist for this student? YES☐ NO☐

2. Diagnosis: _____

_____

_____

3. Original date of diagnosis: _____

4. Expected duration (permanent, temporary, remitting/relapsing):_____

_____

5. Prognosis (progressive, stable, guarded). Use descriptive qualifiers in your assessment of prognosis. _____

_____

6. Describe the student's functional limitations in a residential setting. Include the impact of medication or other treatments. State the degree of the limitation (mild, moderate, severe).

_____

_____

_____

7. Describe any recommendations for specific housing accommodations or other services to address the functional limitations in a residential setting. Include the impact of medication or other treatments. _____

_____

_____

_____

8. Date of most recent visit: _____

9. How frequently are you meeting with the patient?

_____

10. Number of hospitalizations for the above condition(s) within the past year, including length of stay.

_____

_____

11. What other medical treatment, therapies, devices, or medication regimens have been prescribed for this patient.

_____

_____

_____

_____

12. If you have specialty evaluations or reports (e.g. neuropsychological, psychiatric, visual, hearing, speech, physical therapy, occupational therapy, etc.) pertinent to the residential environment for this patient, include a copy or identify the service provider responsible for the evaluation or report.

Please note that you may be contacted in order to clarify information regarding the request.

Your name:

Your title:

Address:

Phone:

State license #:

Thank you!

Please return all materials to:

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