



**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: \_\_\_\_\_

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2. Explain how your request accommodates your condition: \_\_\_\_\_

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

<b>Housing Accommodations Process</b>	<b>Initial</b>
Requests for on-campus housing accommodations must be submitted by: March 15 <sup>th</sup> for Fall housing April 15 <sup>th</sup> for Summer housing November 15 <sup>th</sup> for Spring housing <i>Any requests submitted after the deadline will be considered as space permits!</i>	
A new form must be completed by the student and the Specialist <b>each year</b> special housing accommodations are requested.	
NEW students must fill out the general housing application form and pay their enrollment deposit found <a href="#">here</a>	
<b>Part 1</b> of the Special Housing Accommodation Request Form must be complete and contain the signature & date of the student making the request.	
<b>Part 2</b> 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. <i>Documentation from a family member or friend who is not the primary specialist is not accepted.</i>	
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). <i>The Nazareth University Special Housing Accommodations Committee will make the final determination in providing appropriate and reasonable accommodations.</i>	

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

10. Medication History: Current prescriptions (if generic, include brand name equivalents), dosage, length of time on medication, side effects, and student compliance with medications.

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

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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:

ATTN: Special Housing Accommodations Committee  
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