ASHLAND UNIVERSITY

Student Accessibility Center
Housing Accommodation Verification Form
(To be completed by the student's healthcare provider)

To help determine reasonable accommodations, qualified professionals may submit documentation on behalf of students. Base your conclusions on all evidence in file (clinical and laboratory findings; symptoms; observations, lay evidence; reports of daily activities, etc.). This information will be used in conjunction with the student's self-report to determine reasonable accommodations on an individual basis. Medical information will be considered but is not the definitive information that informs our final decisions. We consider a multitude of factors. A medical provider's recommended accommodation does not automatically bind SAC/AU to approve the accommodation as being reasonable. When recommendations within documentation would primarily enhance academic success or are considered outside the scope of what is necessary for equal access, the student will be referred to other resources and or given options that may be able to address the specific need.

If you have questions regarding this form, please contact Julie Donatini, Director, Student Accessibility Center at: 419-289-5904 or jdonatin@ashland.edu.

Please note: Students requesting to live off-campus and commute must meet the commuter status criteria set by the University policy available on page 23 of the Student Handbook: https://www.ashland.edu/student-conduct.

STUDENT INFORMATION

(To be completed by the healthcare provider - Please Print Legibly or Type)

First Name: _____ Middle Init: _____ Last: _____

Date of Birth: _____

Status (circle one): Current student Transfer student Prospective student

Student Cell phone: _____

Please check which of the following **University-provided accommodations and/or services** you are recommending for the student due to the specific nature and impact of their diagnosis:

Campus Housing Accommodation	✔
Single Dorm Room	
Air-Conditioned Room	
ADA Accessible Suite with building entrance ramp, roll-in shower & private bathroom	
Shared Bathroom (with 1 roommate)	
Private Bathroom (no roommate)	
Lower floor dorm room access - first or second floor	
Enhanced cleaning prior to arrival	
Apartment living with a full kitchen, private or roommate-shared bathroom	
Campus Services	
Counseling Services	
Tutoring & Academic Skills Development	
Writing and Communication Center	
Dietary Restriction Services & consultation with a Registered Dietician/Nutritionist	
Student Health Center Services	
Safety Services	
Professional & Faculty Advising	

1. Does this student have a disability (physical or mental impairment that substantially limits one or more major life activities)? ___ Yes ___ No

   Primary Diagnosis: _____ DSM/ ICD Code: _____

2. When did you **first** meet with the student regarding this disability?

3. When did you **last** interact with the student regarding this disability?

4. What is the **frequency** of your interactions in the past 6 months regarding this disability?

5. Please list the specific symptoms of the diagnoses that will likely impact the student in the campus residential setting.

Symptoms	Severity	Frequency	Duration

6. Please describe in detail how these symptoms create functional limitations for this student in a campus residential setting.

7. Are there any situations or environmental conditions that might lead to exacerbation of the condition(s)?

8. Please describe your recommendations that would meet the student's housing needs as well as the rationale, strongly considering on-campus configurations from page #1. If no on-campus configuration is suitable to meet the disability-related need, please explain why an exemption to the live on-campus University policy is necessary.

9. Please indicate the treatments, medications, devices or services currently prescribed, or used in the past to minimize the impact of the student's diagnosis:

10. Please explain the health impact to this student if the recommended housing accommodations are not met.

HEALTHCARE PROVIDER INFORMATION
(Please sign & date below and completely fill in all other fields using PRINT or TYPE)

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Provider Title: _____

License or Certification #: _____

Address: _____
_____

Phone Number: _____ FAX Number: _____

Email: _____

Please return completed form to: Julie Donatini, Director
Student Accessibility Center Ashland University

401 College Ave
Ashland, OH 44805
Email: jdonatin@ashland.edu FAX: 419-289-5294