Assumption University

Office of Student Accessibility Services

Disability Verification for Housing Accommodation Requests

Assumption University supports and recognizes the standards set forth in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, and its amendments, which are designed to eliminate discrimination against qualified individuals with disabilities. Assumption is committed to providing equity, access, and inclusion of all students with disabilities within the Assumption University community.

By completing Section I of this form, the student consents to allow their physician/clinician to provide information regarding the student's condition to the University's Accommodations Committee (and if necessary, the Appeals Committee) and consents to discussion by appropriate and qualified staff members of the student's request, condition, and resulting determination with the physician/clinician filling out this form. If multiple physicians/clinicians need to provide information, please fill out multiple forms.

Sections II and III of this form must be completed by an appropriate qualified professional (such as a treating or diagnosing health or mental health professional). Forms completed by a family member are not acceptable. For psychological disabilities, evaluation and documentation should be within the last six months unless the condition is one that does not change over time. All accommodation requests will be evaluated on a case-by-case basis by the University's Accommodations Committee. Please note a diagnosis alone does not necessarily qualify the student for the requested accommodation(s). The documentation must also support the need for the accommodation.

Questions should be directed to the chair of the Accommodations Committee, Julie LeBlanc, Senior Director of Student Accessibility and Retention Initiatives at jm.leblanc@assumption.edu.

Section I – STUDENT INFORMATION - *TO BE COMPLETED BY THE STUDENT*

Name: _____ Class Year: _____

First M.I. Last

I hereby give _____ (healthcare provider's name) permission to provide the information requested and to discuss my condition with members of the Accommodations Committee and/or Appeals Committee at Assumption University.

_____ _____

Student Signature (or legal guardian if under 18 years of age Date

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Section II – **PROVIDER INFORMATION -** *TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE CONDITION RELEVANT TO THE REQUEST FOR HOUSING ACCOMMODATION*

Name of Provider: _____

Specialty and License #: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Section III - **MEDICAL INFORMATION** *-TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE CONDITION RELEVANT TO THE REQUEST FOR HOUSING ACCOMMODATION*

Primary Diagnosis: _____ Severity Level: ☐Mild ☐ Moderate ☐ Severe

Secondary Diagnosis: _____ Severity Level: ☐Mild ☐ Moderate ☐ Severe

Based on your clinical experience with the student, does the diagnosis(es) rise to the level of disability as defined by the ADA? ☐ Yes ☐ No ☐ Unsure/Not Enough Information

Duration time that the student has been under your care: _____

Date of last clinical visit: _____

Course of Treatment (ex: medications prescribed, therapies tried, specialty referrals, etc.):

_____

_____

_____

Over the past year, the student's condition has (been):

☐ Stable ☐Improved ☐Worsened

1. Please indicate symptoms and the approximate frequency of symptoms experienced.

   Symptom 1: _____

   ☐ Daily ☐ Monthly ☐ Periodic ☐ Seasonal (Which season(s)? _____)

Symptom 2: _____

☐ Daily ☐ Monthly ☐ Periodic ☐ Seasonal (Which season(s)? _____)

Symptom 3:_____

☐ Daily ☐ Monthly ☐ Periodic ☐ Seasonal (Which season(s)? _____)

2. Please check the major life activity(ies) that are substantially limited by the disability.

Walking		Hearing		Seeing		Self-Care	
Reading		Working		Learning		Breathing	
Lifting		Eating		Sleeping		Concentration	
Speaking		Thinking		Standing		Communicating	
Performing Manual Tasks		Operation of Bodily Functions		Other:			

3. Please describe your recommendations for necessary accommodations. Please include a rationale and explain how each accommodation would mitigate a functional limitation of the student's underlying condition.

_____
_____
_____
_____
_____
_____
_____
_____
_____

4. What are some possible alternatives if meeting your primary recommendation is not possible?

_____
_____
_____
_____
_____
_____

Healthcare Provider's Signature _____ Date _____