Medical/ Psychological Documentation for student Housing Accommodation

The student named below is applying for a medical accommodation within our residence life program. For us to establish whether this student qualifies for medical accommodation, we need your assessment and diagnosis of the student. The completed form can be sent by fax, email, or regular mail. **All documentation received will be kept confidential**, except in cases where we need to consult with other offices on our campus. This information is shared on a need to know basis, and it is subject to FERPA. No information concerning inquiries about accommodations or the documentation will be released without written consent from the individual requesting the medical accommodation.

TO BE COMPLETED BY STUDENT:

Student Name: ____

Student ID#: ____________________________________ Email: __________________________________

Cell Phone Number: _____________________________ Date of Birth: _____________________________

Current Address: ____

I AM REQUESTING:

____ Single Room __________Other

TO BE COMPLTED BY THE MEDICAL/ PSYCHOLOGICAL PROFESSIONAL:

The Above person is a student at Reinhardt University who is requesting housing accommodation based on a disability or diagnosed medical or psychological condition. Your assistance with our evaluation of the student request is greatly appreciated.

Please complete the following questionnaire:

Is the student currently under your care? _____ Yes _______No

If yes, for how long has the student been under your care? __________________________

What was the date of the most recent contact you had with this student: _________________________

What is the student current diagnosis? ____

What date was the student first diagnosed with the disability/ medical condition? ________________

What is the anticipated duration of the condition? _______ lifelong _______ Intermittent

_________More than 6 months _________Less than 6 months ________Others

Life Activity	**Significant Impact**	**How is the life activity impacted by the diagnosed condition?**
Talking		
Hearing		
Breathing		
Standing		
Working		
Reaching		
Lifting		
Sitting		
Walking		
Seeing		
Writing		
Sleeping		
Learning		
Reading		
Thinking		
Concentrating		
Memorizing		
Performing manual tasks		
Caring for oneself		
Communicating/interacting with others		
Other:		

Are there circumstances which may act to exacerbate the student's condition? _____ Yes ____No

If yes, please describe:

____

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What is it about the student condition that makes the requested accommodation a necessity?

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Please feel free to provide any additional information you feel would assist us in determining the student's need for accommodative housing.

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Medical/ Psychological professional's signature: ____

Printed Name of Medical/psychological professional: ____________________________________

Clinical tittle/Field of specialization: ____

License Number: ____

Office Address: ____

Telephone Number: ____

Fax: ___________________________ **Email:** ____

Date: ____

Submit Completed Form to:

Academic Support Office

Reinhardt University

7300 Reinhardt Circle

Waleska, GA301283

Fax #: (770)-720-5602