

Verification Form and Request for Housing Accommodations

Name (Last, first, middle initial)

Shawnee ID#

Campus Address

Primary phone number

Email address

Emergency Contact Info –

Name: _____ Contact Number: _____

Type of Housing Accommodation Request:

I authorize The Office of Accessibility Services at Shawnee State University to receive diagnostic information from my provider.

Provider Name: _____

Student Signature: _____ Date: _____

In order to determine reasonable accommodations for housing, Shawnee State University requires current written documentation of the student's condition from a licensed clinical professional or health care provider. The licensed clinical professional or health care provider must be familiar with the history and functional limitations of the student's condition.

Provider must Complete this page

1. **Diagnosis:** Please list all relevant diagnoses. If applicable, please list all DSM-V or ICD Diagnoses (text and code).

2. Describe the symptoms related to the student's condition that cause significant impairment in a major life activity.

3. Please state the specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the change to housing is necessary for the student.

All documentation submitted to The Office of Accessibility Services is considered confidential.

Provider Information

I certify by my signature below that I conducted the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print name and Title: _____

State of License: _____ License Number: _____

Address: _____ Phone: _____