PETITION FOR DINING ACCOMMODATION

I am requesting a Dining Accommodation for disability related reasons and I grant permission for my provider(s) to release any required information to:

Office of Accessibility Services
Daemen University
4380 Main Street
Amherst, NY 14226
Fax: 716.745-4335
Email: access@daemen.edu

Your medical provider(s) cannot be a family member and must be the specialist you are working with in regards to your specific request or need. The information will be kept confidential; however, members of the Accommodations Committee will review amongst each other and consult with other professionals as necessary.

To be filled out by student (Please Print/ Type):

Name: ____ Date: ___________________

Home address:____ Cell Phone:_______________________________

Starting semester of requested accommodation:____

Requested dining accommodation and reason for request: ____

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I authorize the provider listed below to release confidential information related to my dining accommodation request to the Director of Accessibility Services at Daemen University. I also give my provider permission to discuss my condition with this office.

Name of Provider:____

Provider's Phone:______________________________ Provider's Email:____________________________________

Student Signature: ____

PETITION FOR DINING ACCOMMODATION

TO: Health Care Provider

The above named student has indicated that you can provide supporting documentation and clarification of their needs regarding disability related housing accommodations on Daemen University's Campus. Currently, all first-year students are housed in double or triple rooms and use a shared bathroom with four other students.

The Health Care Provider listed must submit all forms by mail, fax or email:

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Daemen University
4380 Main Street
Amherst, NY 14226
Fax: 716-745-4335
Email: access@daemen.edu

To be completed by Health Care Provider (print/ type):

Today's Date: ________________________

Health Care Provider Name: ____

Health Care Provider Address: ____

____

Health Care Provider Phone: ____

Health Care Provider Fax: ____

The information you provide on the next three pages will be reviewed to determine reasonable accommodations. Please be as detailed as possible. Thank you for your assistance with this matter. By signing below you verify that the information provided in this document is accurate and true.

Health Care Provider Signature: _______________________________________ Date:__________________

License Number/ State:__________________________

Disability Verification Form

Student Name: ___________________________________

Date of initial contact with student:__________________ Date of last contact with student:__________________

Frequency of appointments:____

Accommodations are available to students identified as having a disability. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

> **Examples of major life activities:** major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Based on this definition noted above, does the individual you are treating have a disability?
☐ Yes ☐ No ☐ Not able to answer

Diagnosis/Diagnoses: ____

Date of diagnosis: _________________

Is your principal clinical relationship to the student associated with the diagnoses and/or treatment of the disabling condition for which the student bases the request? ☐ Yes ☐ No

Are you a relative or close friend of the student and/or family? ☐ Yes ☐ No

The prognosis for the medical condition list above is:

- ☐ Permanent/Chronic Long-term: 6-12 months
- ☐ Short-term/Temporary: 6 months or less
- ☐ Episodic (please describe below) Expected duration: ______________

Is the student Asthmatic**:** ☐ Yes ☐ No

Does this student carry an EpiPen or antihistamine for emergency treatment: ☐ Yes ☐ No

Please state the symptoms associated with the student's disability related accommodations request:___________________

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Additional Comments/Questions:

Identify any measure(s) (e.g., medication, treatment, therapy, etc.) the student is using that mitigates the limitations caused by their impairment:

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What is the severity of the condition? Please check: ☐ Mild ☐ Moderate ☐ Severe

Please explain the severity: ____

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Please add any additional information you believe is important in our consideration of the dining accommodation for the student:

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All recommendations are considered. Potentially effective alternatives may be considered as needed. Decisions are made based on the nature of the disability and functional limitations, reasonableness of the request, timeliness of the request and available housing.

Health Practitioners Signature: ______________________________ Date: _____________

Please return this form, along with any supporting documentation to:

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Amherst, NY 14226
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Email: access@daemen.edu

*In addition to this verification form, please attach or provide any information that you feel is relevant in determining appropriate accommodations for this student.