DAEMEN
UNIVERSITY

PETITION FOR HOUSING ACCOMMODATION

I am requesting a Housing Accommodation due to disability related reasons. I grant permission for my provider(s) to release any information related to my accommodation needs 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. Please note, due to the nature of housing logistics, requests for housing accommodations should be made at least 60 days prior to the move-in date. Requests may be made after that time, however they may not be able to be honored due to availability.

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

Name: _____ Date: _____

Home address:_____ Cell Phone:_____

Starting semester of requested accommodation:_____

Requested accommodation and reason for request: _____

_____

_____

_____

_____

I authorize the provider listed below to release confidential information related to my housing 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: _____

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PETITION FOR HOUSING 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:

Office of Accessibility Services
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: _____

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

_____

_____

_____

_____

_____

Life Activity	Limitation on function	Degree of limitation:
☐ Activities of daily living		☐ Mild ☐ Moderate ☐ Severe
☐ Ambulation		☐ Mild ☐ Moderate ☐ Severe
☐ Breathing/Respiratory		☐ Mild ☐ Moderate ☐ Severe
☐ Climate/Environment		☐ Mild ☐ Moderate ☐ Severe
☐ Communication/Social Interaction		☐ Mild ☐ Moderate ☐ Severe
☐ Eating		☐ Mild ☐ Moderate ☐ Severe
☐ Endurance		☐ Mild ☐ Moderate ☐ Severe
☐ Manual Dexterity		☐ Mild ☐ Moderate ☐ Severe
☐ Motor Coordination		☐ Mild ☐ Moderate ☐ Severe
☐ Operations of bodily functions		☐ Mild ☐ Moderate ☐ Severe
☐ Self-care		☐ Mild ☐ Moderate ☐ Severe
☐ Sleeping		☐ Mild ☐ Moderate ☐ Severe
☐ Speaking		☐ Mild ☐ Moderate ☐ Severe
☐ Stress Management		☐ Mild ☐ Moderate ☐ Severe
☐ Other:		☐ Mild ☐ Moderate ☐ Severe

Additional Comments/Questions:
Describe how the functional limitations mentioned above might impact the student in a college residence:

_____

_____

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

_____

_____

Describe specific recommendations you believe are medically necessary, based on the student's functional limitations. Please explain how they are essential for the student's ability to access, use and enjoy their dwelling:

_____

_____

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

_____

_____

_____

_____

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