Request for Housing Accommodation

Office of Student Affairs • Residence Life • (304)457-6213

To request a housing accommodation for a medical reason or a documented disability at Alderson Broaddus University, you must submit information regarding your request and the condition for which you are being treated. Students **MUST** complete page one, and medical providers **MUST** complete the remaining pages and submit on your behalf. **(Your medical provider can not be a family member and must be the specialist you are working with in regards to your specific request or need).** The verification form must be completed in its entirety before a request will be reviewed. By submitting this paperwork you authorize University staff to cross reference this information with your medical provider if necessary. **Medical Providers MUST** mail or fax, (304)457-6213, completed materials and any supplemental materials to:

Office of Residence Life, Alderson Broaddus University, 101 College Hill Drive, Campus Box 2092, Philippi, WV 26416

Student Information (This area is to be completed by the student. Please print legibly or type.)

Name _____ Student ID # _____

Address _____ City, State, Zip _____

Phone _____ Cell _____ Email _____

Requested semester(s): Fall 20____ Spring 20___

I am a: ☐ Returning Student ☐ Incoming Freshman ☐ Transfer Student

I am Requesting: (check all that apply)

☐ a ground floor room ☐ a single room ☐ a room with a private bath ☐ to live off-campus

☐ other:_____

I authorize the provider listed here and in the subsequent documentation to release confidential information related to my medical housing accommodation request to the Office of Student Affairs at Alderson Broaddus University. I also give my provider permission to discuss my condition with this office. This information will be made available to Alderson Broaddus University faculty and staff only on a need-to-know basis.

Provider Name_____ **Provider's Phone #** _____

_____ _____ _____ _____

Student Signature **Date** **Parent Signature** **Date**

(If student is under 18 years of age, parent signature is required)

Personal Statement

Please attach a personal statement supporting your request. This statement should include a fuller description of your housing need; benefits if your request is granted or the consequences if it cannot be met. You will need to include alternatives to your first choice.

Office of Student Affairs (Office Use Only)

Is the request approved ☐Yes ☐No

What accommodations will be made and for what duration? _____

_____

_____

_____ _____

Student Affairs Representative **Date**

Comments:

Medical Diagnosis Verification Form

Medical Provider Please Complete **(Please print or type, if form is illegible it will be returned to the student)**

Date of completion _____/_____/ _____

Provider Name _____

License #/State _____

Address (Street, City, State, and Zip) _____

Phone # _____ Fax # _____

To determine eligibility for medical housing accommodations, Alderson Broaddus University requires current and comprehensive information on the student's condition from the diagnosing physician or health care provider.

Client's Name_____

Date of initial contact with student _____/ _____/ _____

Medical Diagnosis_____

_____

_____

Date of Diagnosis _____/ _____/ _____

Describe symptoms associated with this medical condition _____

_____

_____

Date of Last Contact with Student _____/ _____/ _____

What is the severity of the condition? (Please check one) ( ) Mild ( ) Moderate ( ) Severe

Please explain severity _____

_____

Expected duration of this condition_____

Frequency of appointments with student _____

List current medications including dosage and side effects _____

_____

_____

Long-term medication plan _____

_____

_____

Current compliance with medication plan_____

_____

Prognosis for medication plan (include likelihood of improvement or deterioration and within what timeframe)

_____

_____

_____

_____

Impact of condition on residential success. Please identify the specific major life activities that are compromised by the condition cited above. Indicate severity of these limitations. _____

_____

_____

_____

_____

Suggested Accommodation_____

_____

_____

Reason particular style of housing is needed _____

_____

_____

In your professional opinion, is the requested accommodation (please circle one) medically necessary medically beneficial

Please explain response _____

_____

_____

I verify that the medical information listed above is accurate and true.

_____ _____

Physician Printed Name Physician Signature

Please return this form by June 1 to:

Alderson Broaddus University
Office of Student Affairs
101 College Hill Drive
Campus Box 2092
Philippi, WV 26416