Accessibility Resources
Division of Student Affairs
University of Cincinnati
PO Box 210213
Cincinnati, OH 45221-0213
210 University Pavilion
Telephone: 513-556-6823
Fax: 513-556-1383

Housing Accommodation Medical Professional Form

The University of Cincinnati recognizes that students with disabilities may require a housing accommodation to fully participate in the residential component of the university experience. A disability is a physical or mental impairment that substantially limits one or more major life activities. Specific housing accommodations due to disability must be identified by a qualified professional and approved through Accessibility Resources.

A diagnosis or medical provider recommendation alone does not guarantee the request will be approved. The Accessibility Resources staff considers the nature of the condition's symptoms and all available accommodations and supports when making final decisions and recommendations. The following factors are examined when determining housing accommodations: severity of the condition, timing of the request, feasibility and availability of space. Final determinations are made by Accessibility Resources.

Please take note of the following as you complete this form:

1. **The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition.**

2. **Please complete all parts of this form legibly and as thoroughly as possible.** Inadequate information, illegible handwriting, or missing fields may delay the review process by necessitating follow up contact for clarification. This PDF provides fillable form fields to allow for typed answers. Typed answers are highly recommended.

3. **Please attach any additional documents or information you think would be relevant in determining the student's housing accommodations.**

Please return this form to the student upon completion so that they may upload it with their online request form. If you have questions about this form or require assistance or accommodations to complete this form please contact Accessibility Resources at 513-556-6823 or email accessresoruces@uc.edu.

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Housing Accommodation Medical Professional Form

Student's Full Name _____

Date of Birth _____ Date of last contact _____

I, the undersigned diagnostic/treating professional, certify that the above named student: (Check One)

☐ Meets the definition of a disability as defined by the American's with Disabilities Act & Section 504 of the Rehabilitation Act of 1973.

☐ Has a medical condition that impacts them but does not rise to the level of a disability,

☐ Does not have a condition that would require the requested modification(s).

1. Please list the student's disability/medical condition and current symptoms:

2. Please provide a detailed explanation of how the disability impacts the student's ability to function specifically within the residential environment**. NOTE:** *Simply stating, "John has X and needs a single room" is not sufficient*

3. Expected duration of disability and its impact on the student within a residential setting

☐Permanent ☐Temporary ☐Remitting/relapsing

If temporary or remitting/relapsing, please explain expected duration of impact on the student.

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Please type answers.

4. How are symptoms/disability currently being treated or controlled? Describe other medical treatments, therapies, devices, or regimens prescribed including compliance, and response to intervention.

5. Are there specialty evaluations or reports (e.g. neuropsychological, psychiatric, vision, hearing, speech, physical therapy, occupational therapy, etc.), pertinent to living in a residence hall environment, for this patient, please list: include a copy if possible, or identify the service provider so AR can discuss it with the student.

6. Please provide any additional information pertinent to the student's request for a housing accommodation.

In the following section please complete the following steps:

1. Select the housing accommodation(s) necessary for the student to manage their symptoms. (Check all boxes that apply).
2. If multiple accommodations are selected, rank order their priority based on the student's current functioning (1 being the highest priority).
3. Please provide a detailed description of how the accommodation is an integral part of the student's treatment plan, the rationale as to why it is warranted and how it will diminish the impact of the disability within a residence hall environment. Any recommendations for accommodations should refer specifically to the functional limitation regarding the requested accommodation. The description must clearly delineate the impact of the disability on the student's functioning in a residence hall setting.

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Please type answers.

Rank	Accommodation	Please provide a detailed description of how the accommodation is an integral part of the student's treatment plan, the rationale as to why it is warranted and how it will diminish the impact of the disability within a residence hall environment.
	☐Single Room (no shared common space)	
	☐Single Bedroom (a private bedroom with shared common space)	
	☐Access to Kitchen	
	☐Private Bathroom	
	☐Semi-Private Bathroom (limited number of people have access)	
	☐Extra Refrigerator	
	☐Deaf and Hard of Hearing Emergency Alerts (e.g. visual fire alarms, bed shakers)	
	☐Wheelchair Accessibility	
	☐Other:	

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Please type answers.

CERTIFYING PROFESSIONAL

Name & Title: _____

Place of Employment: _____

Address: _____

Daytime Phone _____

Fax Number _____

Specialty or license: _____

_____ _____

Signature of Certifying Professional Date

_____ _____

Print Name License #/State Date

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Please type answers.