CHAMPLAIN COLLEGE

# Housing Accommodations Request Form

In order to request an accommodation for your on-campus housing assignment, please complete this form in its entirety. This form must be submitted directly to the Office of Accessibility via mail, email, or fax:


Office of Accessibility, Champlain College
163 South Willard St. Burlington, VT 05401
Email: accessibility@champlain.edu
Phone: (802) 865-5764
Fax: (802) 860-2764


The Office of Accessibility evaluates requests for student housing accommodations on behalf of the Office of Housing & Residential Life. An individual with a disability is someone with a physical or mental impairment that substantially limits one or more major life activities. Additional documentation must substantiate a diagnosed disability.

**DEADLINES: Please review the deadlines outlined on the Office of Accessibility's Housing Accommodations webpage.**
Students may request housing accommodations after the deadline, however they may be placed on a waitlist.

Student Name ___________________________________________ Preferred Name ______________________________

Personal Pronouns ____________________ Date of Birth ________________ Phone Number _______________________

Student Email ___________________________________________________ Student ID Number ____________________

**STUDENT SIGNATURE & CONSENT**

Please sign this form before providing it to your healthcare provider for completion:
*By signing below, I consent to allowing my healthcare provider to share any information relevant to my need for a housing accommodation, as shown on this form, with the Office of Accessibility.*

Signature _________________________________________________________ Date _____________________________

**To ensure provision of reasonable and appropriate accommodations for students, this office and the Office of Housing & Residential Life require current and comprehensive documentation of the disability from a current healthcare provider (treatment/assessment professional) who is legally qualified to make the diagnosis.**

Students who wish to request disability-related housing accommodations must have this form completed by a qualified healthcare provider, which may be a certified physician, other diagnosing medical professional, or specialist. The individual completing this form must have first-hand knowledge of the student's current condition and be an impartial professional who is not related to the student. *The Office of Accessibility will not accept disability-related documentation from treatment professionals who are related to the student requesting services. In order to provide the appropriate analysis to documentation received, the Office of Accessibility must be able to rely on the treatment professionals with the highest capacity for objectivity.*

Once this completed form is received, the Office of Accessibility will review the request to determine whether the request is reasonable and appropriate. The review process can take up to ten business days. Disability needs will take priority over specific residence hall, and/or roommate requests.

For additional information about Housing Accommodation Requests, please visit our website.

**The following information MUST be completed by a PROVIDER (CERTIFIED TREATMENT PROFESSIONAL)**

*If more space is needed to respond to the prompts below, please attach additional pages as needed.*

**1. Diagnosis & Relationship:**

A. Diagnosis:

B. Date of first meeting with student regarding their diagnosis:

C. Date of last contact with student:

D. How many times have you met with this student regarding their diagnosis?

**2. Please describe symptoms that meet the criteria for this diagnosis and report evaluation and assessment results:**

A. Symptoms:

B. Severity:

C. Duration:

D. Expected Long-Term Impact:

**3. What instruments, tests/assessments, diagnostic procedures were used to diagnose the medical condition?**

*Please attach relevant results (i.e. audiogram, functional capacity evaluations, diagnostic test results, etc.).*

**The following information MUST be completed by a PROVIDER (CERTIFIED TREATMENT PROFESSIONAL)**
*If more space is needed to respond to the prompts below, please attach additional pages as needed.*

**4. Prognosis & treatment information:**

A. Please describe prognosis (short/long term) for this condition:

B. Is the student currently receiving treatment or therapies under your care? If so, please describe.

**5. How the disorder exhibits itself in a college residential housing setting:**

A. Please describe how this disorder exhibits itself as a current substantial limitation to a major life activity in a college residential housing environment:

B. Are there any situations/environmental conditions that may exacerbate the student's diagnosis?

C. If the student is currently prescribed medication for their condition, are there any present side effects of medication that substantially limit the student in a college residential housing setting?

**The following information MUST be completed by a PROVIDER (CERTIFIED TREATMENT PROFESSIONAL)**
*If more space is needed to respond to the prompts below, please attach additional pages as needed.*

**6. Recommended Housing Accommodation(s):**

A. Please list the recommendations you have for housing accommodations that would help this student access the college residential housing setting. *Please include a rationale relevant to this student's functional limitations*:

B. How would the student's symptoms be alleviated by the proposed housing accommodation(s)?

C. What consequences, in terms of disability symptomatology, may result if the accommodation request is not approved?

**7. Is there any additional information you wish to share with the Office of Accessibility?**

Signature ____________________________________________________________ Date ______________________________

Print Name and Title ________________________________________________________________________________________

Type of License:________________________ Licensure State:_____________ *License # _____________________________

Address ______________________________________________________________________________________________

Phone ___________________________________ Email ___________________________________________________________

*The information that you provide is maintained in the Office of Accessibility according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).*

*Please note: license number if applicable. Requests will not be processed without provider signature.