SUNY Cortland
Disability Resources Office

Medical/Disability Housing Accommodations Request Form

LICENSED PHYSICIAN / PROVIDER DOCUMENTATION GUIDE FOR MEDICAL/DISABILITY HOUSING ACCOMMODATION REQUESTS

To provide Housing Accommodations for Medical Reasons, SUNY Cortland requires students to submit this detailed assessment by a qualified health professional describing their disability to the Disability Resources Office.

Assessment is to be completed by the licensed medical professional who made the diagnosis and return this form with original signature to the Disability Resources Office address below.

Air-conditioning in residence halls are only available until mid-September on a limited basis.

Indicate the specific request your medical documentation will mention. All documentation received must state you need the accommodation(s) requested. No rooms will be assigned without this completed form and documentation.

Student's name: ____

Room Types (Circle ONE): Single Double Suite Quad West Campus Apartment (2 Mile from Center of Campus)

Check Accommodations

- ◊ **Wheelchair accessible toilet, sink and shower facilities**
- ◊ **Wheelchair accessible bedroom**
- ◊ **Building with ·automatic opening power doors**
- ◊ **Housing with accessible parking**
- ◊ **Hall with elevators**
- ◊ **Bed Shaker**
- ◊ **Visual alerting devices**
- ◊ **Release from residence hall contract (room and board)**
- ◊ **Hall with air conditioning**
- ◊ **Assistance/Emotional Support Animal (Separate Documentation packet needs to be completed)**

Other:________________________________

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HEALTHCARE PROVIDER'S ASSESSMENT **(To be filled out by PROVIDER)**

Health professional's name (please print): ____

Date: ____________________________

Clinic name and address: ______________________________

____

Clinic Phone:____

Place Stamp Here

HEALTHCARE PROVIDER'S ASSESSMENT (CONT.)

What is the diagnosis? (Include DSM-V diagnosis code or method/evaluation (lab work etc.) used to determine diagnosis) ____

____

Date diagnosis was made?____

Summary of symptoms for which the treatment started:____

____

What treatment has been implemented?____

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Is the patient/student currently under your care? ____

____

When did you last see the patient/student? ____

____

What are the **<u>Functional Limitations</u>** resulting from the diagnosis that impact on major life activities, which include but are not limited to: **caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, & working** as related to the patient/student living in on-campus housing?____

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Based upon the major life activities affected by the diagnosis, are there any accommodations within the context of the college housing that you can recommend for this student?

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____ ____________________

Signature of Attending Licensed Healthcare Provider and Title Date

Please have your provider complete this form and mail it to:
Sue Sprague
Director, Disability Resources Office
SUNY Cortland
PO Box 2000 – B-1 Van Hoesen Hall
Cortland, NY 13045
(607) 753-2967
Scan Documentation to: Suzanne.sprague@cortland.edu