



Accessible Campus Community & Equitable Student Support (ACCESS)

t 618.650.3726 F 618.650.5691 e myaccess@siue.edu w siue.edu/access
a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, Illinois 62026-1611

Housing Accommodation Verification Form

Student Information

Student Name: _____

Student 800#: _____ Date: _____

I authorize Accessible Campus Community & Equitable Student Support (ACCESS) at SIUE to release and/or receive information from the provider below. I also authorize my provider to discuss my condition(s) with the ACCESS office for the purposes of approving housing accommodation(s):

Student Signature: _____

Upon completion by physician, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.

Licensed Provider Information

Name of Provider: _____

Title: _____

Phone Number: _____

License/Certification Number: _____

I certify that the information below is true and accurate.

Signature: _____

Practice Name and Address
(Stamps Welcome)

Information about the Student's Disability (An individual with a disability is described under section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits or affects one or more major life activities (i.e. eating, seeing, hearing, etc.) and/or major bodily functions (i.e. digestion, bowel, bladder, immune system, respiratory, endocrine, etc.) Please be detailed and specific in response to each item as this will assist in evaluating this student's request for dietary accommodation (the provider completing this form should not be a relative of the student).

Yes, the student is diagnosed with a health condition requiring housing accommodation due to a documented disability-related condition.

For what condition are you treating the above referenced student?

How long has the student had this condition? _____

What is the severity of the condition? (Please Check One) Mild Moderate Severe

What is the expected duration of this condition? _____

Please list (if applicable) the student's current medication(s), dosage, frequency, and adverse side effects, as they may relate to University Housing:

Length of time under your care (please include date of first and last contact and the frequency of appointments:

Please provide a brief description of the major life activity or bodily function that is affected by the disability:

Describe the functional limitations of the student's condition as it relates to housing:

Is the requested accommodation: Medically Necessary Medically Beneficial

(please check one and explain response below):

Please outline specific recommendations for this student, including a rationale as to what environmental changes are needed, or what other accommodation is necessary based upon the student's functional limitations. (i.e. if you suggest a private bedroom, please state the reasons for this request related to the student's functional limitations and disability):