REQUEST FOR DISABILITY RELATED HOUSING ACCOMMODATIONS
Qualified Health Professional Disability Verification Form

Albion College is committed to fostering an inclusive and supportive living environment for all students, including those with documented disabilities. This policy outlines the process and the documentation required to obtain housing accommodations due to a disability. The aim is to ensure that students with disabilities are provided equitable access to campus housing through reasonable accommodations.

Albion College provides reasonable accommodations to persons with disabilities who have a verifiable need for the reasonable accommodation because of a disability as defined by the Americans with Disabilities Act (ADA). A reasonable accommodation is an exception to the usual rules or policies that a person with a disability needs because of their disability to have an equal opportunity to use and enjoy Albion College owned housing.

Documentation must be provided by a licensed or credentialed professional, with specific training or expertise related to the condition being diagnosed, who has diagnosed or is currently treating the student. This request form must be fully legible for processing. Please feel free to attach a typed page with each numbered response.

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (Student completes)

I authorize my provider listed below to release health care information to Albion College. Furthermore, I authorize my provider to discuss my condition(s) with the appropriate and qualified Albion College personnel on an as needed basis.

Provider Name: _____ Provider Specialty: _____

Address: _____ Phone: _____
Street City State Zip Code

Student's Name: _____ DOB: _____

Student's Signature: _____Date: _____

Student ID: _____ Class year: FR SO JR SR

Parent/Legal Guardian signature is required if the student is under 18 years of age.

Parent/Legal Guardian signature: _____ Date: _____

TO BE COMPLETED BY TREATING PRACTITIONER

Today's Date: _____

For purposes of this verification, ***a disability is defined as a physical or mental impairment with an actual or expected duration longer than 6 months that substantially limits one or more major life activities or major bodily functions as compared to most people in the general population.***

1. Does this person have a disability under this definition? Yes No

2. Please identify the disability and the diagnostic code(s) of the condition(s) (e.g. DSM-V or ICD-10).

_____

3. Date of last clinical contact with student related to this disability: _____

4. Has this disability impairment lasted for more than 6 months? Yes No (If no, please explain expected length of disability impairment.)

_____

5. Please indicate the level of impact the student's disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Attending class regularly					
Caring for oneself					
Communicating					
Concentrating					
Hearing					
Interacting with others					
Interacting socially					
Learning					
Making/keeping appointments					
Managing distractions					
Managing stress					
Meeting deadlines					
Memorizing					
Organization					
Performing manual tasks					
Reading					
Seeing					
Sleeping					
Thinking					
Writing					

6. Please describe how the student's disability impairment substantially limits their ability to perform a major life activity or bodily function as compared to most people in the general population:

_____

_____

7. What reasonable accommodation **is essential** to allow the student to use and enjoy campus housing?

_____

8. Please describe the identifiable relationship between the accommodation recommendation and the disability impairment (how will the student's disability impairment be improved by the essential accommodation?).

_____

_____

MEDICAL/HEALTHCARE PROVIDER INFORMATION

THIS SECTION MUST BE COMPLETED, SIGNED OR STAMPED WITH PROVIDER'S OFFICE INFORMATION

The provider completing this form cannot be related to the student

I certify, by my signature below, I diagnosed or am currently treating the student named above.

Provider's Signature: _____Date: _____

Printed Name and Title: _____

State of License:_____ License Number: _____

Address: _____

Phone: _____ Fax: _____

To Return Directly send to : accessibility@albion.edu or Fax: 517-629-0528

Adapted from Otterbein University