HOUSING EXEMPTION REQUEST
Verification Form

Albion College is a residential campus that values the social development and academic success that coincide with the residential experience. We will engage in a process to offer solutions for on-campus residence life accommodations necessitated by a disability. Medical documentation and preferences will be taken into consideration during that process but may not be equal to the final solutions offered by the College as appropriate on-campus accommodations meant to fulfill the disability-related need. Our goal is to ensure that all students have the ability to safely and substantially attend classes, live on campus, and abide by College policy.

Albion College is a residential campus with an on campus housing requirement. Reasonable accommodations are provided 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) and most needs can be met in campus housing. The student listed below is requesting to be exempt from the campus housing requirement due to medical reasons.

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 treated the student within the past 90 days. 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. Diagnostic statement: identify the disability and the diagnostic codes of the condition (e.g. DSM-V or ICD-10).

_____

_____

3. Date of diagnosis: _____

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

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

_____

_____

6. 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					
Other:					

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

_____

_____

_____

8. Has there been a documented or reported substantial decline of the student's original medical/psychological condition? Yes No

9. **If yes**, please **check any of the following** observations which apply and describe the timeframe below:

□ Increase in number of symptoms
□ Persistence of symptoms
□ Increase in the subjective level of client distress
□ Increase in severity of symptoms
□ Decreased functional impairment

_____

_____

10. Please circle the most appropriate statement (A or B) and explain as necessary.

A. **On-campus housing accommodations** will suit my patient's needs to support his/her mental and physical well-being and I have discussed this with the student. The following **accommodations are essential** (please rank order needed accommodations as all are not available together):

____ Single room/single room in apartment
____ Low/No stairs
____ Semi-private bathroom
____ Private kitchen (stovetop/oven)
____ Shared kitchen (stovetop/oven)
____ Air Conditioner
____ Carpet-free room
____ 1st floor room
____ Wheelchair accessible room
____ Private bathroom
____ Emotional Support Animal
____ Meal plan exemption
____ Door flasher or visual door knocker
____ Alternative Lighting (non-fluorescent)
____ Top floor room
____ End/corner unit
____ Unlofted bed
____ Service Dog
____ Strobe fire alarms

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

_____

_____

B. It is in my professional opinion that on-campus housing accommodations will not suit my patient's mental and/or physical health/needs – **it is essential my patient live off-campus**.

Please explain why off-campus housing is essential, how it offers the most suitable environment not provided in on-campus housing or apartments, and the health impact if the request is not met (clarify if a single-family house is needed):

_____

_____

_____

_____

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, that 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 form DIRECTLY: **Accessibility Services/Cutler Center** **Email: accessibilty@albion.edu**
Fax: 517-629-0578