DAEMEN

STUDENT AFFAIRS

PETITION FOR HOUSING ACCOMMODATION

I am requesting a Housing Accommodation disability related reasons, I grant permission for my provider(s) to release any information related to my accommodation needs to:

Office of Disability Services
Daemen University
4380 Main Street
Amherst, NY 14226
Fax: 716.745-4335
Email: ddimitro@daemen.edu

Your medical provider(s) cannot be a family member and must be the specialist you are working with in regards to your specific request or need. The information will be kept confidential; however, members of the Accommodations Committee will review amongst each other and consult with other professionals as necessary.

To be filled out by student (Please Print/ Type):

Name: _____ Date: _____

Home address:_____ Cell Phone:_____

Requested accommodation and reason for request: _____

_____

_____

_____

_____

I authorize the provider listed below to release confidential information related to my housing accommodation request to the Director of Disability Services at Daemen University. I also give my provider permission to discuss my condition with this office.

Name of Provider:_____

Provider's Phone:_____ Provider's email:_____

Student Signature: _____

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PETITION FOR HOUSING ACCOMMODATION

TO: Health Care Provider

The above named student has indicated that you can provide supporting documentation and clarification of their needs regarding disability related housing accommodations on Daemen University's Campus. Currently, all first-year students are housed in double or triple rooms and use a shared bathroom with four other students.

The Health Care Provider listed must submit all forms by mail, fax or email:

Office of Disability Services
Daemen University
4380 Main Street
Amherst, NY 14226
Fax: 716.745-4335
Email: ddimitro@daemen.edu

To be completed by Health Care Provider (print/ type):

Today's Date: _____

Health Care Provider Name: _____

Health Care Provider Address: _____

_____

Health Care Provider Phone: _____

Health Care Provider Fax: _____

The information you provide on the next page will be reviewed to determine and approve reasonable accommodations. Please be as detailed as possible. Thank you for your assistance with this matter. By signing below you verify that the information provided in this document is accurate and true.

Health Care Provider Signature: _____ Date:_____

License Number/ State:_____

Medical Diagnosis Verification Form

Student Name: _____

Date of initial contact with student:_____ Date of last contact with student:_____

What is the medical diagnosis of the condition for which this student is requesting accommodation?

_____

Date of diagnosis: _____

Please state the symptoms associated with the student's disability related accommodations request:

_____

_____

_____

What is the severity of the condition? Please check: Mild [ ] Moderate [ ] Severe [ ]

Please explain the severity: _____

_____

_____

What is the expected duration of the condition:_____

Frequency of appointments:_____

List current medications and their side effects:_____

_____

_____

Students Compliance with the medication plan:_____

What are the functional limitations that may be impacted by the condition stated above?

_____

_____

_____

In your professional opinion, is the requested accommodation (please check one):

[ ] medically necessary or [ ] medically beneficial

Please explain response: _____

_____