UNIVERSITY OF
NORTHERN COLORADO

Disability Resource Center

Housing Accommodation Documentation Form

Student's Name: **Date:**

In order to properly evaluate the student's request for Housing Accommodations at the University of Northern Colorado, the Disability Resource Center requires specific diagnostic information from a licensed clinical professional or healthcare provider who is directly responsible for the treatments of the student's diagnosed disability, including the intentional use of housing accommodations to address the functional limitations that result from the student's physical or psychological condition(s).

As a qualified professional within your respective field, you should be diligent in following your professional training, scope of practice, and applicable ethics codes when considering this student's request. When completing this form please consider; does the student making the request have a diagnosis of disability which substantially limits their ability to equally access campus housing and do you believe that the recommended accommodations serve a role to successfully mitigate and contribute to the treatment of the impacts of the disability.

It is important to note that a diagnosis or medical provider recommendation does not guarantee that the student's request for housing accommodations will be approved. The Disability Resource Center and the Housing Accommodation Committee complete a holistic review of the provider's recommendations, current nature of the student's symptoms, student's self-report, and all available accommodations and university supports when making final decisions and recommendations.

We ask that you please complete this form in its entirety, providing complete answers for all questions. If you are unable to provide a response for a question please indicate the reason. It is not necessary to submit additional documentation for this student's request, however if you feel that additional information may provide a more complete understanding of the student's request you are welcome to submit additional information.

Upon completion, submit the form by email (drc@unco.edu) or fax (970-351-4166). Please do not hesitate to contact our office (phone: 970-351-2289) with any questions or concerns. Your assistance with our evaluation of the student's request is greatly appreciated.

Certifying Licensed Medical or Mental Health Professional

By signing below, you are verifying that you were solely responsible for completing this form, the information reflects your responses to the questions, you are treating this student, and are not a relative of the student.

Name:___________________________________ **Title:**______________________________

Area(s) of Specialization:____

State of licensure/Certification:_________ **License/Certification Number:**_______________

Phone Number:___________________________ **Fax:**___________________________

Provider Signature:____ **Date:**__________

Student Name: ____

1) Provide a description of the student's current diagnosis and disability-related symptoms. Please include frequency and duration of symptoms, if applicable.

2) The anticipated prognosis of the medical condition/disability:
   □ Permanent/chronic □ More than 6 months □ Short-term/temporary: 5 months or less
   □ Episodic: Expected duration:_____________

3) Is the student currently under your care? □ Yes □ No

4) Date of most recent visit:________

5) How long have you been working with the student regarding this diagnosis? _________

6) Does the student require ongoing treatment? Please explain.
   □ Yes:____

   □ No:____

7) Does the student's condition substantially impact a major life activity (e.g., seeing, hearing, eating, sleeping, walking, self-care, etc.) or bodily function (e.g., digestion, respiratory, circulatory, etc.)?
□ No (please explain):____
____

□ Yes-If yes, please check only those areas of functioning and major life activities impacted by the student's condition, explain its impact on the identified areas/activities, and circle the level of severity.

Area of functioning/major life activities (check)	How is this area of functioning/major life activity impacted by the diagnosed condition?	Severity of limitation
□ Hearing		Mild Moderate Severe Do not know
□ Vision		Mild Moderate Severe Do not know
□ Speech		Mild Moderate Severe Do not know
□ Walking		Mild Moderate Severe Do not know
□ Sitting		Mild Moderate Severe Do not know
□ Standing		Mild Moderate Severe Do not know
□ Motor coordination		Mild Moderate Severe Do not know
□ Self-care activities		Mild Moderate Severe Do not know
□ Endurance		Mild Moderate Severe Do not know
□ Respiratory		Mild Moderate Severe Do not know
□ Cognitive functioning		Mild Moderate Severe Do not know
□ Sleep		Mild Moderate Severe Do not know
□ Eating		Mild Moderate Severe Do not know
□ Social interactions		Mild Moderate Severe Do not know

□ Other:		Mild Moderate Severe Do not know

8) What accommodations do you recommend in housing based on this student's diagnosis and functional limitations?

9) In what ways will the proposed housing accommodations help to alleviate symptoms and the impact of the student's disability?

10) In your professional opinion, how important is it for the student's well-being that these accommodations be provided in housing? What consequences, in terms of disability symptomology, may result if the accommodation is not approved?