Verification Form for Students Requesting Changes to the Housing Environment

Due to a Significant Chronic Physical or Emotional Condition

NOTE: THIS IS ONLY FOR A HOUSING ACCOMMODATION. It is recommended this form is completed when you complete your housing contract online.

In order to evaluate how Indiana University can best meet a student's needs for special housing assignment requests, the University requires specific diagnostic information from a licensed clinical professional or health care provider. This professional/ health care provider should be familiar with the history and functional limitations of the student's physical or psychological condition(s). The student must complete section one of the form. This information and the student signature is required so that the appropriate and qualified member of the Indiana University staff (housing assignments, dining, or disability services) has permission to speak with the professional/provider who completes the information in section two to discuss the student's condition or resulting determination. The professional/health care provider must fill out section two, sign, and return the completed packet to the RPS Housing Assignments Office. **Failure to complete both sections completely will result in the form not being reviewed.** The form will be reviewed and the recommendations of the medical provider along with the availability of space that will meet the medical need will be considered.

Mail: RPS Housing Assignments Office, 801 N. Jordan Ave Room D101, Bloomington, IN 47405
Email: housing@indiana.edu

For Spring 2017: Forms submitted before December 1, 2016 will receive priority.
For Fall 2017: Forms submitted before May 1, 2017 will receive priority.
Forms received after this date may not be reviewed.

Please Note: If a student needs academic or other related accommodations, please contact the Disability Services for Students Office at 812-855-7578 or iubdss@indiana.edu.

SECTION ONE

Student fills out this section.

Student Name:

Student ID:

Birth Date:

Email:

Gender: Female

Home Address:

Home City:

Home State:

Home Zip:

Home Phone:

Cell Phone:

I request consideration for the following term: Fall 2017

I request consideration for the following reason: Room Change

By typing your name in the signature box, having this section two of this form completed by your health care provider, and submitting this form to Indiana University Department of Residential Programs and Services (RPS), you:

Acknowledge that my medical condition may impact or limit my housing options, including roommate and location on campus, so that RPS can place me in an assignment that meets my needs. This medical request takes precedent over all other room preferences submitted in my housing application.

Understand that RPS staff may find it necessary to consult with IU Disability Services for Students and/or the IU Health Center about my request and needs, and authorize them to do so in considering my request.

Authorize Indiana University to receive information from the medical professional/provider below. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Indiana University personnel on an as needed basis.

Student's Signature:

Date:

SECTION TWO

Medical/Health Care Provider fills out and signs section below.

Student's Name:

Date of Birth:

To determine special assignment consideration, Indiana University requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). The provider completing this form cannot be a relative of the student. Items 1 thru 4 must be completed in full. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

Provider Completes the Section Below. Please respond to the following items in regards to the student named above.

Date of Initial Contact with Student:

Date of Last Office Visit with Student:

What is the student's medical condition/diagnosis for each of the following (enter information for all that apply)?

Allergies / Asthma:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Blindness/Visual Impairment:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Deafness or Hard of Hearing:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Diabetes:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Food Allergy:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

ADD / ADHD:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Mental Health / Emotional Disorder:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Mobility Limitation:

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Other (specify):

Date of diagnosis:

What is the severity of condition, and how long is the condition likely to persist?

Describe the symptoms and state the specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's medical (physical or emotional health) condition. Indicate why the change(s) to the housing environment you recommend are necessary:

Describe the current treatment and/or therapy plan:

If the condition is related to respiratory conditions or allergies, which room type is the best option:

Window Air-conditioner

The provider may also send a report that provides additional related information.

The provider completing this form cannot be a relative of the student.

Signature of Provider:	
Date:	
Name:	
Title:	
Address:	
Phone:	
License Number:	
State:	