Armstrong Atlantic State University
Request for Housing Accommodation

The Offices of Disability Services, Housing and Residence Life, and Plant Operations work closely together to evaluate requests for housing accommodations for students with disabilities. Students requesting special accommodation or modification to University Housing must complete and submit this form in order to receive consideration. In addition, the student requesting accommodation must also have a current fully completed housing application on file before the University will evaluate a request for housing accommodation. A request for housing accommodation does not guarantee a housing assignment.

Student should complete Section I and the medical provider should complete Section II. This request must be completed in its entirety before a request will be considered. All requests for accommodation must be made at least 60 days prior to arrival.

Documentation must substantiate a diagnosed impairment that is a current substantial limitation to a major life activity as it relates to housing needs. To ensure the provision of reasonable and appropriate on-campus accommodations for students, the University requires current and comprehensive documentation of the disorder from a current treatment/assessment professional qualified to make the diagnosis. (Please note, a diagnosis in and of itself does not automatically qualify for requested accommodation).

This request form must be submitted each year in order to review and renew, as appropriate, accommodations provided through the Offices of Disability Services and Housing and Residence Life.

______________________________________________________________________________

Section I. Student completes this section (Please print or type)

Student Name: _________________________________________________________________ (Last)                                             (First)                     (Middle initial)

Birth Date: ____________________              Gender:   Male ___________   Female __________

Home Address: _________________________________________________________________

Home Phone Number: _____________________     Cell phone number: ___________________

Email Address: _______________________________

Requested Accommodation: (What structural modifications, special equipment etc. are you requesting and explain how the requested accommodation relates to your disability i.e. first floor room due to mobility limitations):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Academic year for which you are requesting accommodation: __________________________

Please list any special equipment that you will bring and use which relates to your disability (e.g. wheelchair, specialized computer equipment, etc.):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list any special equipment that you are requesting from the Office of Disability Services and/or Housing and Residence Life, which relates directly to your disability (e.g. emergency alarm flasher, etc.):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Authorization and Release to Disclose Medical Information

The information I have provided above is accurate to the best of my knowledge. I authorize the Office of Disability Services to discuss my medical condition and request for housing accommodation with the Director of Housing and Residence Life, the Director of Plant Operations, my health care provider(s) and other University officials who may have a need to know about my condition in order to evaluate my request for accommodation.

Student’s signature: _____________________________________________________________
Student’s printed name: __________________________________________________________

Parent’s signature (if student is less than 18 years old): ______________________________
Parent’s printed name: __________________________________________________________

Parent’s address: _______________________________________________________________
Parent’s phone number: _________________________________________________________
Section II. Completed by treating physician or appropriate medical provider

The student identified herein is requesting reasonable accommodation be made to allow him or her to live on-campus in a University residence hall. The information requested is to document the student’s disability, the severity of the disability and to help determine reasonable accommodation. All disability related requests require appropriate and complete documentation. This form should be completed by the appropriate medical professional. The information will be protected as a confidential file in the Office of Disability Services.

Student’s Name: ________________________________________ Date: __________________

1. Name of disability/disorder/health condition that you have diagnosed:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

2. Tests or evaluations used to make the diagnosis:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

3. List current medication(s), dosage and frequency, adverse side effects, if any, and potential impact on the student’s ability to live in a community environment:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Please describe the severity of the condition and its probable impact on (or limitations imposed by) the student’s living situation at the University:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
5. Please describe housing accommodations needed by the student based on functional limitation(s) caused by the student’s specific disability/disorder/health condition:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

6. Please assess if the student is at risk in the event of an emergency evacuation (for example-fire):
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Certifying Medical Professional
Name (print): _______________________________________________________________
Signature: __________________________________________________________________
License Number: ____________________________________________________________
Address: ___________________________________________________________________
Phone Number: _________________________ Fax: ________________________________
Email address: ______________________________________________________________

This information will be reviewed and accommodation decisions made in accordance with the policies of Armstrong Atlantic State University. All housing assignments are made by the Office of Housing and Residence Life. For further information please contact the Office of Disability Services, 912-344-2744 or by fax at 912-344-3068 or on the web at http://sa.armstrong.edu/Disability/housing.html Return this completed form to Office of Disability Services, Armstrong Atlantic State University, 11935 Abercorn Street, Savannah, GA 31419-1997.