REQUEST FOR HOUSING ACCOMMODATIONS – HEALTH CARE PROVIDER FORM

*__Student Name__: _____ *__DOB:__ _____

To be eligible for housing accommodations, your patient/client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and the Americans with Disabilities Amendments Act of 2009. These laws define a person with a disability as one who: (1) has a physical or mental impairment which substantially limits one or more major life activities; or (2) has a record of such impairment; or (3) is regarded as having such impairment. "Major life activities" may include but are not limited to functions such as walking, seeing, hearing, speaking, breathing, learning, performing manual tasks, and working.
Indicates required field

***Practitioner Name/Title**: _____ ***Date**: _____

***Address**: _____

***Telephone Number**: _____ ***License or Certification Number**:_____

Qualification to make diagnosis: _____

***Date of most recent appointment with this student**:_____

1. ***Student's specific diagnosis/diagnoses. Please include expected duration:**

   _____

   _____

   _____

2. ***Severity of Student's Condition (Mild, Moderate, Severe, etc.):**

   _____

   _____

3. **Please list all current medications:**

   _____

   _____

   _____

   _____

4. ***Check all relevant functional limitations that are substantially limited by this disability:**

   _____Ambulating _____Hearing _____Vision _____Working _____Sleeping _____Breathing

   _____Communication skills _____Performing activities of daily living _____Learning (including memory/concentration)

   Other (Please be specific): _____

5. ***Please explain how each functional limitation will specifically affect the student's ability to live in the residence hall:**

EMMANUEL COLLEGE

ARC
Academic Resource Center

_____

_____

_____

6. ***Please suggest reasonable accommodations. Each accommodation must be supported by the diagnosis. Please provide a rationale for each suggested accommodation as it relates to a specific functional limitation.**

_____

_____

_____

7. ***Please state an alternative accommodation which can effectively meet the documented need of the student, if the preferred accommodation request cannot be reasonably met.**

_____

_____

_____

8. ***Please discuss the impact on your patient's/client's disability if the preferred accommodation can't be granted**.

_____

_____

_____

Signature of Health Care Provider**_____ Date**: _____

The provider cannot be a family member of the student.

Please Return This Completed Form To:

Noelle Galli
Disability Support Services Accommodation Coordinator
Emmanuel College
400 The Fenway
Boston, MA 02115
617-732-1681
Confidential Fax: 617-975 9322
gallin@emmanuel.edu

IMPORTANT - AS OF 3/16/20 – ALL REQUEST FORMS MUST BE SCANNED AND EMAILED TO GALLIN@EMMANUEL.EDU AS THE CAMPUS IS WORKING REMOTELY AT THIS TIME.