CSB/SJU Student Accessibility Services
37 S College Ave
St Joseph, MN 56374

Housing Accommodation
Documentation Form

The student named below is requesting accommodations due to the impact of a disability. To evaluate that request, Student Accessibility Services requires additional information completed by a qualified professional, who:

1) Has first- hand knowledge of the student's condition and current health status.
2) Can answer questions based on specialty and/or professional scope.
3) Is an impartial individual not related to the student.

The included form will be used as documentation to support a housing accommodation request. For proper consideration, responses must describe the current impact of the disability on academic performance or experience outside of the classroom. Please be advised that accommodations are made to ensure equal access to residential opportunities, not to accommodate individualized preferences.

This completed form can be returned via:
Fax: (320) 363-6097
Mail: Student Accessibility Service, HAB 105, 37 S College Avenue, St. Joseph MN 56374

AUTHORIZATION TO RELEASE INFORMATION I AUTHORIZE:

- My provider to provide the information below to Student Accessibility Services. This includes mental health information,
- My provider to discuss my condition, with Student Accessibility Services, if more information is necessary beyond this form.
- Student Accessibility Services to receive information from the provider below.

Student Name___________________________________ Date of Birth: _______________________________________

Provider Name: __________________________________Clinic: ____

Student Signature: ________________________________Date: ____

Certifying Professional (To be completed by the qualified professional)

Name (Please Print): ____

Professional Title: ____

License/Certification Number and Issuing State(s): ____

Clinic/Agency Name: ____

Address: ____

City: ______________________________________ **State**: ____________________________**Zip Code**: ____________

Phone: _______________________________**Fax**: ___________________________________

Verification of Disability:

Accommodations are available to students identified as having a disability. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that **substantially limits** one or more major life activities."

> **Examples of major life activities**: major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Based on this definition noted above, does the individual you are treating have a disability?

☐ yes ☐ no ☐ Not able to answer.

Based on your professional scope, can you confirm whether the student meets any of the following disability categories: Choose all that apply to the student's disability:

☐ Deaf/hard of hearing ☐ Physical Disability ☐ Speech/Language impairment
☐ Blind/visually impaired ☐ Mental/Psychiatric ☐ ADD/ADHD
☐ Learning disability ☐ Autism Spectrum ☐ Brain Injury
☐ Systemic Disability ☐ Other (please specify): ____

State the student's primary diagnosis and secondary diagnosis/es with corresponding ICD-10 codes:

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Did you diagnose this individual with the abovementioned condition(s)? ☐ Yes ☐ no

Date of Diagnosis: _________ Date of your most recent evaluation: _____________

Is your principal clinical relationship to the student associated with the diagnoses and/or treatment of the disabling condition for which the student bases the request? ☐ Yes ☐ no

Indicate your role in the student's health care management process (check all that apply):

☐ Primary Care/Family Physician
☐ Single Session Provider
☐ Counselor/Psychotherapist
☐ Psychiatrist
☐ Crisis Intervention/Trauma Therapy
☐ File Review
☐ Other: _____________________

Are you a relative or close friend of the student and/or family? ☐ yes ☐ no

The prognosis for the medical condition or disability above is:

☐ Permanent/Chronic Long-term: 6-12 months
☐ Short-term/Temporary: 6 months or less
☐ Episodic (please describe below) Expected duration: ______________

Life Activity	Degree of substantial impact:	How is the life activity impacted by the diagnosed condition within a campus residence?
☐ Activities of daily living		
☐ Ambulation		
☐ Breathing/Respiratory		
☐ Climate/Environment		
☐ Communication/Social Interaction		
☐ Eating		
☐ Endurance		
☐ Manual Dexterity		
☐ Motor Coordination		
☐ Operations of bodily functions		
☐ Self-care		
☐ Sleeping		
☐ Speaking		
☐ Other:		

Additional Comments/Questions:

Based on the functional limitations described above, what housing accommodation(s) is essential to ensure that the student has the same opportunities as non-disabled peers:

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What makes the accommodation necessary?

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Are there any equivalent alternative options that may need to be considered based on the student's circumstances?

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Add any additional information you believe is important in our consideration of residential accommodations for the student:

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All recommendations are considered. Potentially effective alternatives may be considered as needed. Decisions are made based on the nature of the disability and functional limitations, reasonableness of the request, timeliness of the request and available housing.

Health Practitioners Signature: ____ **Date**: __________________

Please return this form, along with any supporting documentation to:
CSB/SJU Student Accessibility Services CSB HAB 105 37 S
College Ave
St. Joseph MN 56374
Phone: 320-363-5245
Fax: 320—363-6097

In addition to this verification form, please attach or provide any information that you feel is relevant in determining appropriate accommodations for this student.