Housing Accommodation Request Form

Student Request

To be completed by student:

Name:	MC ID#:
Campus Box:	MC E-Mail:
Phone:	DOB:
Semester/Year of Request:	New/Transfer/Returning Student:

Please list specific housing accommodation(s) and explain the need based upon a documented disability.

Request*

Justification*

Student Signature: _____

Date: _____

*Note - The Accessibility Committee reviews requests to ensure that the claimed disability is a "substantially limiting condition" as defined by the Americans with Disabilities Act.

Physician Documentation

I give permission for the exchange of any medical, educational, or psychiatric information between the Office of Student Disability Services and the members of the Accommodation Committee.

Student Signature: _____

Name of Diagnosing Professional:
Title of Diagnosing Professional:
Address:
Phone/Fax:

This section of the form must be completed by the diagnosing professional, who should not be a relative of the student.

1. Diagnosis

2. What major life activity does the condition substantially limit?

3. Describe the current impact of the condition.

4. Original date of diagnosis: _____

By: _____
Name

_____
Degree/Specialty

5. Diagnostic criteria/tests used.

6. Date of most recent evaluation: _____

7. Treatments/medications/devices or services currently prescribed.

8. Expected duration, stability, or progression of the condition.

9. Recommended housing accommodations.
   - ❑ Single Room
   - ❑ Wheelchair Accessible Unit
   - ❑ Semi-private Bathroom
   - ❑ Private Bathroom
   - ❑ Accessible building (no steps at building entrance, elevator, and accessible common areas)
   - ❑ Partially accessible building (elevator building or ground floor unit with no steps at entrance)

❑ Limited accessible building (some steps at building entrance, elevator building or ground floor unit)

❑ Other: _____

10. Describe how the recommended housing impacts the condition:

11. Alternative recommendations.

12. Additional comments (optional).

If you are prescribing an emotional support animal for an accommodation for a disability, please answer the additional questions.

13. Have you observed the student interacting with the animal? If yes, please list your observations from the interaction.

14. Is the animal an appropriate fit (size, age, etc.) for the small space and elevated noise of a campus residence room and hall? Please note that a comfort/emotional support animal is

only allowed in the student's residence hall room and in the assigned waste elimination space.

Name of Diagnostician: _____

Signature: _____

Date: _____

In addition to this form, please include, ON PROFESSIONAL LETTERHEAD, the date of the most recent office visit of the student, your professional credentials, and your signature.

Please return to the Director of Disability Services, by mail:

Morgan L. Bryant, Ph.D., LPC
Director of Disability Services
Box 4016
Clinton, MS 39058

OR by fax:

601-925-7793

Deadlines

One month prior to the residence hall opening each semester.