Health Care Provider Verification ~ Modified Housing/Dining Requests

University of New Haven

To be completed by Health Care Provider ONLY! (Please Print or Type)

Student's Name ____
Last *First* *MI*

University of New Haven Campus:

☐	UNH West Haven Campus (West Haven, CT)
☐	UNH New London Campus (New London, CT)

The University of New Haven provides reasonable accommodations and support services to students with disabilities. In order for us to determine eligibility for these accommodations and services, a student must submit documentation of a disability as defined in Section 504 of the Rehabilitation Act or the Americans with Disabilities Act Amendments Act (ADAAA). ***Section 504 and the ADAAA define disability as a physical or mental impairment that substantially limits one or more major life activities. Major life activities are listed below and also include the operation of major bodily functions such as, but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.*** Documentation from the diagnosing professional must be comprehensive and current. (The diagnosing professional completing this form cannot be a relative of the student). **Items 1 through 7 must be completed in their entirety, EXCEPTING -*Item 2***, *which* **must** *be completed for students requesting modifications to dining.*

If space provided is not adequate, please attach additional sheets. **The provider may also attach a report providing additional related information.**

1. What is the student's medical condition/diagnosis? ______________________________
   a) How long has the student had this condition? (Date Diagnosed) ______________________
   b) Date of last appointment regarding this diagnosis: ______________________________
   c) Major Life Activity and Impact of this condition on student's functioning:

Functional Limitation	Mild	Moderate	Severe	Comments
Caring for Oneself				
Performina Manual Tasks				
Seeing				
Hearing				
Sleeping				
Eating				
Speaking				
Walking				
Standing				
Lifitng				
Bending				
Breathing				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Major Bodily Function				

d) For Asthma, please indicate severity below:

☐ Intermittent	☐ Mild Persistent	☐ Moderate Persistent	☐ Severe Persistent

e) How long is this student's condition indicated above likely to persist?

☐ temporary 0-6 mos ☐ 6 mos - 1 year ☐ 1 – 5 years ☐ lifelong

2. ***Complete if the student is requesting Modifications to Housing and/or Dining related to specific dietary needs*** *

Please explain the specific dietary needs of the student as related to the condition/diagnosis:

☐Student must eat and/or avoid certain foods (please explain/list foods in detail): ______________________________

____

____

☐Student has specific dietary needs which require eating at specified times and/or time intervals (please explain in detail):

____

____

☐Other specific dietary need (please explain in detail): ______________________________________

____

____

3. Has the student been hospitalized for this condition? ☐Yes ☐No (If Yes, please complete the following)

a) How frequently has student been hospitalized? ______________________________________

b) Date of most recent hospitalization: ______________________________________

c) What exacerbated the condition to the point of hospitalization? ______________________________________

____

4. List the student's current medication(s), dosage, frequency and adverse side effects experienced by this student.

Medication	Dosage	Frequency	Adverse Side Effects

a) Is there a significant impact to the student's functioning in an academic setting directly related to the prescribed medications? ☐ Yes ☐ No If Yes, Please describe: ______________________________________

5. Please state the ***specific recommendations regarding housing or dining accommodations for this student along with a rationale*** as to why these accommodations are warranted based on the student's ***current*** functional limitations. Indicate why the housing or dining accommodations you recommend are necessary. (e.g. If you suggest a private bathroom, state the reasons for this request as related to the student's condition.)

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6. If current treatments (e.g. medications) are successful, why are the above accommodations necessary?

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____

____

7. Are there any unusual circumstances surrounding this condition that would help us make an appropriate decision regarding accommoations for this student?

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Please attach any additional information you feel will be helpful to us in assisting the student with his/her request for consideration of modification to housing or dining options.

Signature of Professional/Provider ___________________________ Date _______________

License # ____ State _______

Please Type/Print the Following:

Name/Title: ____

Address: ____

____

Telephone ( )_________________________ Fax ( ) _____________________________

A staff member of the Accessibility Resources Center, Health Services or Counseling & Psychological Services may need to contact you for clarification purposes. Please list the best times to contact you:

____

This document may not be released without written permission from the student, except in cases of disclosure as required/allowed by FERPA. It will be destroyed seven years after the student is no longer enrolled. FERPA allows the student access to this document, and copies of this document, but you may specify that this access be given only after meeting with a person qualified to explain the document.

Check ONE: _______ Student Access
_______ Student Access Only after meeting with qualified professional

Office Use Only

☐ Approved ☐ Denied Date________________ Date Student Notified_________________

☐ Tabled for further documentation Date________________ Date Student Notified_________________

Comments: ____

____

ARC Signature: ___________________________________

☐ Appeal Approved ☐ Appeal Denied Date________________ Date Student Notified_________________

DOS Signature: ___________________________________