QUEENS
UNIVERSITY CHARLOTTE

Supporting Documentation for Housing Accommodation Request

Provider (Physician, Nurse Practitioner, Psychiatrist, Psychologist, Counselor, Social Worker, or other healthcare professional):

The Queens University of Charlotte student named on this form has identified you as their health care provider, who has recommended a housing-related disability accommodation to ensure equal access to and full participation in campus residential life.

To consider this student's request for an accommodation based on a disability, Queens University of Charlotte requires documentation from the treating and licensed clinical professional or health care provider familiar with this student's condition and their functional limitations. The information you provide will be used to evaluate the student's request for accommodation. Please take the time to complete this form in its entirety and/or provide all requested information.

All information provided to us is kept confidential within the Student Accessibility Services Office in accordance with the Family Educational Rights and Privacy Act (FERPA).

Return Completed Form to:

Student Accessibility Services
Center for Student Success 1900 Selwyn Avenue
Charlotte, NC 28274

Fax: 704-688-2738

Email: SAShelp@queens.edu

Student Name: Date:

Student Date of Birth:

Student ID (if known):

Part I: Information about the student's disability and proposed accommodations

1. What is the student's relevant diagnosis(es) that falls under your scope of practice?

2. What major life activity or activities or bodily functions does the diagnosis impact? (e.g., walking, seeing, hearing, breathing, self-care, etc.)

3. Describe the current severity and duration (including stability and progression, if applicable) of the student's functional limitations or disability-related impacts (this may include negative impact that may occur if request is not granted).

4. What is the original date of diagnosis? Please include the name and degree/specialty of the individual who diagnosed the student. Please describe diagnostic criteria/tests used.

5. What is the date of the most recent evaluation or assessment that you completed with the student?

6. Please include a list of treatments, medications, devices, or services the student is currently prescribed and other specialists or providers in their care team (if applicable).

7. Please describe your professional recommendations for housing accommodations based on the student's disability and functional limitations.

8. Please describe how **each** specific housing recommendation serves to alleviate the impact and severity of impact of the student's disability and functional limitations.

9. If there are other housing accommodations that may also meet the student's need, please describe those alternatives below.

10. **OPTIONAL:** Please provide any additional comments below.

Part II: Provider information

Provider's Name:

Profession/Specialty:

Address:

Phone:

Email:

11. If you are related to this student, what is your relationship?

12. What is your professional licensure/certification? (e.g. Licensed Professional Counselor):

License/Cert. #:

State:

Licensing Organization: