Dartmouth

Documentation for Accommodation Needs

To request an accommodation for a student's housing assignment because of a disability or chronic health condition, information from the treating and licensed clinical professional or health care provider must be submitted to Undergraduate Housing. The professional/provider must be thoroughly familiar with the student's physical or psychological condition(s) and resulting functional limitations and/or restrictions. We require that the professional/provider completing these forms is not a family member through blood, marriage or other legal arrangement. The student must complete the top portion of the form below. The student, or their parent/legal guardian if under the age of eighteen (18), must fill out and sign the Authorization to Release Health Care Information below. This signature provides permission to the health care provider to complete the information requested on this form and to speak with an officer of Dartmouth College's Undergraduate Housing Office and its representatives including Student Accessibility Services and the College Health Service (which the Undergraduate Housing Office consults as appropriate) regarding this request for a housing accommodation. The provider must fill out the remainder of this form and sign it. This completed form can be submitted to the addresses below:

Fax: 603-646-1677
Mail: Undergraduate Housing Office
Dartmouth College
6231 North Massachusetts Hall
Hanover, NH 03755
Email: residential.life@dartmouth.edu

Student fills out the section below. Please print or type.

Student's Name:

____
(Last) (First) (MI)

Dartmouth ID Number: __________________ Class Year: ________________

Term Requested accommodation is requested to begin (please circle):

Fall Winter Spring Summer

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Authorization to Release Information

I authorize the provider listed below to release information and medical records related to my request to Dartmouth College Undergraduate Housing Office for the purpose of an accommodation to my housing assignment because of a disability, and to discuss this request with a representative of Undergraduate Housing, if necessary.

Name of Provider: ____

Specialty: ____

Address (Street, City, State and Zip): ____

____

Accommodation for a student's housing assignment because of a disability or chronic health condition supersedes all other requests, including roommates.

I have read and understand the above information.

Student's Signature

____ Date _____________________

Parent/ Legal Guardian Signature, if student is under 18

____ Date ____________________

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Medical/Health Care Provider Completes and Signs Section Below

STUDENT’S NAME ____

Provider Completes the Section Below:

To consider this student’s request for an accommodation because of a disability/chronic health condition in his/her housing assignment, **Undergraduate Housing requires documentation of the student’s current medical condition and medical records** from the treating and licensed clinical professional or health care provider thoroughly familiar with this student’s condition and his/her functional limitations and/or restrictions. Items 1 through 4 must be completed in full. If the spaces provided are not adequate, please attach a separate sheet of paper.

Please respond to the following items regarding the student named above:

1. Student’s disability/diagnosis:

   a) When was this condition first diagnosed?

   b) How would you describe the severity of this condition?

   c) When was the student/patient last seen by you?

   d) What treatment or medications have been prescribed?

2. Does the student’s disability/health condition significantly limit any major life activities?
If yes, please describe the limitations and/or restrictions in detail.

3. Please state specific recommendations regarding the accommodation(s) this student needs in their housing assignment **AND** explain why such an accommodation is warranted, based upon the student’s physical or psychological condition(s).

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4. For how long do you consider the information you provide in Items 1-3 above to be valid without reassessment and/or updated information?

[ ] The circumstances described in this form are **permanent and stationary**

[ ] The circumstances described in this form may not be permanent or stationary, but I expect no significant change through ________________, __________
Month Year

All fields below must be complete to process

Signature of Provider

____ Date_____________________

License # and state and/or other pertinent credentials:

____

____

Print Name & Title

____

Address

____

____

____

Phone ____

Fax ____