Housing - Disability Accommodation Form

In order to evaluate how the University of the Incarnate Word (UIW) can best meet a student's needs for housing accommodations, the University requires specific diagnostic information from a licensed physician, psychologist/psychiatrist, clinical social worker or other healthcare professional who is **not related** to the student. This professional should be familiar with the history and functional limitations of the student's disability. The student must complete this page of the form. Also, to facilitate the process, UIW requires the student to fill out and sign the Authorization to receive disability-related information found below. This signature makes it possible for the staff of Student Disability Services to speak with the individual who completes the diagnostic part of this form and permission to discuss the student's disability. The licensed professional providing documentation of a disability must fill out pages two and three, sign and date, and then return the completed packet to:

Mail: **Student Disability Services**
University of the Incarnate Word
4301 Broadway, CPO #286
San Antonio, TX 78209

Fax: **210-829-6078**

Student Fills Out Section Below. Please Print Clearly or Type

Student Name: ____
(Last) (First) (Middle)

Social Security #:______________________________

Birth Date: ______________________________

Home Address: ______________________________

____
City State Zip

Home Phone: ______________________________

Student Classification:

_____ Entering Freshman
_____ Freshman
_____ Sophomore
_____ Junior
_____ Senior
_____ Transfer
_____ Graduate Student

Email: ______________________________

Gender: ______ Male ______ Female

Local Address: ______________________________

____
City State Zip

Local Phone ______________________________

&/or Cell: ______________________________

Authorization to Receive Disability-Related Information

I authorize the University of the Incarnate Word – Office of Student Disability Services to receive information from the licensed professional below. I also authorize the licensed professional to discuss my disability with the Office of Student Disability Services staff.

Name of Licensed Professional: ______________________________

Relationship to Student: ______________________________

Address: ______________________________ Phone: ______________________________

____
City State Zip

Certifying Licensed Professional Fills Out Section Below. Please Print Clearly or Type

Student's Name: ______________________________________ **SSN:** ________________________

Certifying Licensed Professional completes the section below:

To determine eligibility for housing accommodations, the University of the Incarnate Word requires current and comprehensive documentation of the student's disability from the licensed professional or health care provider familiar with the history and functional limitations of the student's disability. The licensed professional completing this form **cannot** be a relative of the student. **Items 1 thru 5 must be completed in full**. If the space provided is not adequate, please attach a separate sheet of paper. The licensed professional may also attach a report providing additional related information.

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

1) What is the student's disability/diagnosis: ____

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   a. How long has the student had this disability? ___________________________________

   b. What is the severity of the disability? ____

   ____

   c. How long is this disability likely to persist? ______________________________________

2) Describe the symptoms related to the student's disability that cause **significant impairment** in a major life activity:

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3) List this student's current medication(s), dosage, frequency, and adverse side effects:

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a. Are there any significant limitations to the student's functioning directly related to the prescribed medications? _______ Yes _______ No

If yes, please explain: ____

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____

4) Please state specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the housing accommodation(s) you recommend are necessary (i.e., if you suggest a private room – state the reasons for this request related to the student's disability).

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5) If current treatments (i.e., medications, etc.) are successful, why are the above accommodation recommendations necessary?

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NOTE: The licensed professional completing this form cannot be a relative of the student

Signature of Licensed Professional: ______________________________ Date: ______________

License #: ______________________________ State: ______________________________

(Please Print) Name/Title: ____

Address: ____

____
City State Zip

Phone: ______________________ Fax: ______________________

Thank You

The licensed professional may also send a report that provides additional relative information