COLLEGE of CHARLESTON
CENTER FOR DISABILITY SERVICES

Housing Accommodation Request Provider Form

Students with documented disabilities may request necessary accessible alternate housing arrangements. This form must be completed and signed by the clinician/treatment specialist, not the student.

To ensure the provision of reasonable accommodations for students with disabilities at College of Charleston, documentation must be provided by a qualified professional, with experience and expertise in the area for which accommodations are being requested. Documentation must be current and provide comprehensive information regarding the student's disability.

By providing this form to a qualified diagnostician/clinician, the student is granting permission for a member of the Housing Committee at College of Charleston to contact and consult with the professional regarding their recommendation for the student's requested accommodation.

Please note that an assignment to a specific residence area cannot be guaranteed. All requests will be reviewed by the Housing Committee (Center for Disability Services, Student Health Services, Counseling Center, Residence Life and any other College of Charleston office that might be relevant to the decision-making process). Requests are for individuals, not for groups of students.

I am completing this form for:

_____
Student's First Name Last MI

This request is being made for:

☐ Fall ☐ Spring Year: 20_____

The student has been a patient of mine since_____ and they are requesting disability-based housing accommodations that I certify are medically necessary.

Please provide the details of the disability diagnoses, below, including a summary of treatment and length of time you have been treating the student.

Current Relevant Diagnosis	**Diagnosis Date**	**Severity** (mild/moderate/severe)	**Anticipated Duration** (short term/episodic/chronic)

Please indicate the accessibility accommodation being requested, the functional limitations of the student's disability, and why this accommodation is necessary to address the symptoms of the disability:

Functional Limitations: Please indicate level of impact on major life activity:

Functional Area	Substantial	Moderate	Mild	None	Don't Know
Communicating					
Hearing					
Seeing					
Mobility (walking, climbing, stairs, etc.)					
Sleeping					
Caring for self					
Interacting with others					
Other					

CERTIFICATION OF THE DISABILITY AND NEED FOR ACCESSIBLE HOUSING ACCOMMODATIONS.

The following is to be completed by the medical professional certifying the disability and need for the accommodations.

First Name _____ Last _____

Practice/Place of Employment _____ (____) Office Number _____

Address of Employer _____ Email _____

City _____ State _____ Zipcode _____ Date _____

Signature _____

Please use agency stamp or attach your business card here.

Please return the completed, signed document to the College of Charleston Housing Accommodation committee by emailing the form to: cds@cofc.edu.