Division of
Student Life
Housing and Residential Communities

The University of Alabama

Housing-Related Medical Accommodation Request Form

The University seeks to provide students with disabilities reasonable accommodations in UA-owned housing in order to afford the student equal access to its housing. To consider a student's request for a reasonable accommodation in housing, Housing and Residential Communities requires documentation of the student's current disability from the treating and licensed clinical professional or health care provider thoroughly familiar with this student's condition and functional limitations and/or restrictions. Said professional or provider shall not be a family member through blood, marriage or other legal arrangement. ***Completion of this form is not necessary if a student's disability is visible or obvious.***

See housing.ua.edu for appropriate deadlines. Once completed, please submit the form using either method below:

Fax: 205.348.7135

Mail: Jim Barron
Housing and Residential Communities
Robert E. Witt Student Activity Center
Box 870399
Tuscaloosa, AL 35487

To be completed by requesting student:

Student full, given name: _____

Student CWID: _____ Cell Phone: _____

Crimson Email: _____ Personal Email: _____

I am (check all that apply): ☐ an incoming freshman ☐ an incoming transfer ☐ a returning student
☐ requesting cancellation ☐ requesting exemption

Requested Roommate *{Roommate requests may not be granted due to space limitations or accommodation}:*

1. Name: _____ CWID: _____

☐ I have read the Medical Requests portion of housing.ua.edu.

☐ I understand that if I submit my Housing-Related Medical Accommodation Request Form after the deadline date my roommate preference(s) may not be considered.

☐ I understand that if I am interested in a room change during the contracted period, I will be limited to available rooms that can reasonably accommodate my disability.

☐ I understand that I must contact the Office of Disability Services to request any **academic** accommodations.

☐ I understand that specific building requests will not be considered.

☐ In evaluating my request, Housing and Residential Communities may need to consult the Student Health Center and the Office of Disability Services. As such, I authorize Housing and Residential Communities to discuss information about me, including any health information, medical condition or disability, to the Student Health Center, the Office of Disability Services or other appropriate UA office.

Student Signature: _____ Date: _____

HOUSING-RELATED MEDICAL ACCOMMODATION REQUEST FORM

STUDENT'S NAME _____

To be completed by requesting student's physician/clinician. Psychiatric disabilities should be documented by a professional trained to diagnose and treat these conditions. This form must be completed in full and signed. If the space provided is not adequate, please feel free to respond to the questions on letterhead and submit with the remainder of the form completed.

Please respond to the following items regarding the student making the request:

1. Federal laws define a person with a disability as "any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

a) Does the student have a physical or mental impairment? Yes ☐ No ☐

b) If yes, what is the impairment?

Please answer the following questions based on what limitations the student has when their condition is in an active state and no mitigating measures are used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

c) Does the impairment substantially limit a major life activity? Yes ☐ No ☐

d) If yes, what major life activity(s) is/are affected? (Check all that apply)

Caring for self	☐	Sleeping	☐
Interfacing with others	☐	Speaking	☐
Seeing	☐	Thinking	☐
Performing Manual Tasks	☐	Hearing	☐
Breathing	☐	Standing	☐
Sitting	☐	Concentrating	☐
Walking	☐	Learning	☐
Toileting	☐	Other (Describe)	☐ _____

e) How long has the student been under your care? _____

f) When was the student/patient last seen by you? (MM/DD/YYYY) _____

g) How long is this impairment likely to continue?

2. Please indicate which of the following housing accommodations you suggest based upon the student's condition:

Wheelchair-accessible room/building	☐	Storage space for medical supplies	☐
Wheelchair-accessible shower/bath	☐	Landline phone (limited availability)	☐
Kitchen access	☐	Adaptive access technology	☐
Close proximity to restroom facilities	☐	Vibration alarm	☐
Strobe alarm	☐		
Other (Describe)	☐		

_____

HOUSING-RELATED MEDICAL ACCOMMODATION REQUEST FORM

3. Please describe why the suggested accommodations are necessary to enable the student to reside in UA-owned housing.

Other comments:

Signature of Provider: _____ Date:_____

License # and state and/or other pertinent credentials:_____

_____

Print Name & Title: _____

Address:_____

Phone: _____ Fax: _____