REQUEST FOR INFORMATION
Housing and/or Dining Accommodation Request

Please note: Your health care provider is not required to use this specific form. However, all the information requested here is necessary for the institution to consider any request for Housing and/or Dining accommodation(s). This form is provided as a convenience. If you choose not to utilize this form, any letter from your health care provider must be on their official letterhead. Documentation without letterhead will not be accepted.

STUDENT

Student's Printed Name: _____

Email: _____ Phone: _____

Please sign this form before providing it to your health care provider to complete.

By signing below, you consent to allowing your health care provider to share any information relevant to your need for accommodation(s), as shown on this form, with the Fairmont State University Office of Accessibility Services Coordinator for the next sixty (60) days.

_____ _____
Student Signature Date

Recommended practitioners for accepted documentation

The following practitioners are accepted to provide documentation on the respective disabilities or conditions (all must be appropriately credentialed and licensed in their respective fields):

Disability or Condition	Acceptable Practitioner
Attention Deficit Hyperactivity Disorder	Neuropsychologist, Clinical Psychologist, Psychiatrist, Neurologist, Neurodevelopmental Physician
Chronic Illness/Health	Gastroenterologist, Rheumatologist, Endocrinologist, Internal Medicine, or other physician knowledgeable of condition
Developmental Disability (such as Autism Spectrum Disorder)	Neuropsychologist, Psychiatrist, Clinical Psychologist, Neurodevelopmental Physician
Head Injury/TBI	Neurologist, Neuropsychologist to include general medical physicians
Hearing	Audiologist (CCC-A), Otolaryngologist
Learning Disabilities	School Psychologist, Clinical Psychologist, Neuropsychologist, Neurodevelopmental Physician
Mental Health or Psychiatric	Psychiatrist, Clinical Psychologist, Social Worker (LCSW), Marriage/Family Therapist, Licensed Professional Clinical Counselor, Psychiatric Nurse Practitioner
Mobility/Physical	Physical Therapist, Orthopedic Surgeon, other physician knowledgeable of condition
Speech and Communication Conditions	Speech Language Clinician
Vision	Optometrist, Ophthalmologist

HEALTH CARE PROVIDER

Fairmont State University is dedicated to ensuring that students with disabilities are able to fully participate in all aspects of University life. We believe that living on campus and being part of the campus community are integral parts of a student's college experience. We strive to meet the housing and dining needs of students with documented disabilities as defined by the Americans with Disabilities Act (ADA).

In order to determine reasonable accommodation, Fairmont State University requires current and comprehensive documentation of the student's disability. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities or bodily functions. It is important to note that, under the law, determination of accommodation should be based on need and effectiveness, *not preference*. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider who is familiar with the student and their diagnosed disability and the impact it has on their functioning. *The provider completing this form cannot be a relative of the student.*

Your role as a licensed care provider is to thoroughly articulate the functional limitations of a student's disability (a sentence or two is *not* sufficient). Functional limitations are ways in which the student's disability limits their functioning in major life activities and bodily functions.

The Accessibility Coordinator will be responsible for determining which accommodations are appropriate to provide equal access, based on the functional limitations identified by you the provider, the institutional knowledge of Fairmont State University's resources and processes, and the technical standards of the students' classes.

1) Date of Initial Contact with Student: _____

2) Date of Last Office Visit with Student: _____

3) ***Diagnosis:*** Please list all relevant diagnoses. If applicable, please list all DSM 5 or ICD Diagnoses (text and code):

_____

_____

4) Approximate onset of diagnosis: _____/_____/_____

5) Please describe how the student's disability impairment **substantially** limits their ability to perform a major life activity or bodily function (i.e. walking, hearing, seeing, sleeping, etc.) as compared to most people in the general population, specifically in relation to the student's housing and/or dining experience, as well as the frequency and duration of the impairment.

_____

_____

_____

_____

6) What treatment is the student receiving to address the symptoms and severity of the conditions described above (therapy, medication, etc.), if any?

_____

_____

7) What specific recommendations for accommodation(s) do you have regarding housing and/or dining? Indicate if any recommendations are medically necessary.

_____

_____

8) For each accommodation(s) listed above, please explain how the accommodation(s) will mitigate the impact of the student's disability in relation to campus housing and/or dining. There must be an identifiable relationship between the students' disability and the accommodation being requested.

_____

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9) If the Office of Accessibility Services does not approve the requested accommodation(s), what would be the impact on the student relative to the campus housing and/or dining experience?

_____

_____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax, email or mail to the Office of Accessibility Services at Fairmont State University.

All documentation submitted to the Office of Accessibility Services is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

Please return this form to:
Fairmont State University
Office of Accessibility Services
1201 Locust Avenue
Fairmont, WV 26554
Phone: (304) 367-4543
Email: access@fairmontstate.edu
Fax: (304) 367-4584

Attach Provider Business Card Here