

LVC Student ID Number: _____

Housing Accommodation Verification Form: Medical Provider Information: (This form is to be completed by a health professional only if the student has a documented medical/mental health need that requires special accommodation). Please complete the following information to assist Lebanon Valley College in determining your patient's need for Special On Campus Housing Accommodations. The information you provide will become a part of your patient's medical record at Lebanon Valley College and may be utilized by Student Affairs or the Center for Accessibility Resources in accommodating your patient's medical needs. If this form is not filled out completely or legibly, the form will be returned back to the student.

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits a major life activity". Examples of major life activities are: walking, speaking, breathing, hearing, seeing, thinking, sitting, sleeping, working, learning, interacting with others, concentrating, performing manual tasks, or caring for oneself.

1. Based on this definition does the individual have a physical or mental impairment? YES NO

2. Please answer the following questions:
 - a. What specifically is the diagnosis(es)? Please use DSM categorization and coding

 - b. Date of diagnosis: _____

 - c. Is the Student currently under your care: (Circle one) YES or NO If no longer under you care, when did care end?

 - d. Length of time under your care: _____

 - e. Which major life activities are affected by the diagnosis(es)? _____

 - f. How many days did the diagnosis(es) limit major life activities during the past year? _____

 - g. Severity of the condition (Please Circle): Mild, Moderate, Severe

 - h. Does the student take medication for this condition? YES NO

If YES, please list: _____

3. What other treatment modalities does the student use? _____

4. Please explain how the disability will specifically affect the student in the higher education environment.

5. Please state specifically what special on campus housing and/or meal plan accommodations are recommended for the student and explain how each accommodation relates to needs arising from the student's disability.

6. In your opinion, is this accommodation medically necessary to afford the student an equal opportunity to use and enjoy College housing? If yes, please explain.

7. Please state alternatives to meet the documented need if the first request cannot be met.

8. Please discuss the impact on your client's disability if accommodation cannot be granted.

FORM completed by: (PLEASE PRINT or type)

Provider Name: _____ Provider License #: _____

Provider Specialty: _____

Address: _____

Phone: _____

***Provider Signature:** _____ **Date** _____

****My signature verifies that I am or have been this student's treating health care provider, that I have personally completed this form, that the contents are true and accurate, and that I am not a relative of the student.***

Please return completed form to:

**STUDENT AFFAIRS OFFICE
Lebanon Valley College
101 N. College Ave, Annville, PA 17003
Email: res-life@lvc.edu**