Plymouth State University
Campus Accessibility Services

Housing Accommodation Request-Part II Provider

To be completed by a licensed provider and returned to Campus Accessibility Services.

The student identified in part I has indicated that you are the treatment provider who has suggested that having reasonable housing-related accommodations at PSU will be helpful in alleviating one or more of the identified symptoms or effects of the student's disability.

An appropriate licensed diagnostician or qualified clinician (e.g. primary physician, nurse practitioner, physician's assistant, licensed mental health professional, etc.) must complete this form in full. **A response to all questions is required.** The diagnostician must have an established provider/patient relationship with the student, have provided treatment for the disabling condition, and be an impartial individual who is not a family member.

Student/Patient Name: _____

Current diagnosis(es): _____

_____

Date of diagnosis: _____ Last Evaluation: _____

How long has the student/patient been under your care for this diagnosis? _____

Are you currently providing the student/patient treatment for this diagnosis? (circle one) Yes No

Anticipated duration of the condition: (check one)

- ☐ Temporary (ex. Broken bone); approximate duration: _____
- ☐ Ongoing: no clear recovery date, but condition(s) may improve during the student/patient's time at college.
- ☑ Permanent: little, to no possibility of recovery

Campus Accessibility Services
PSU.CAS@plymouth.edu
17 High St. MSC 9 | Plymouth, NH 03264 | Tel: 603.535.3300 | fax: 603.535.2277

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Please complete the following chart:

**Major life functions may include but are not limited to breathing, caring for self, communicating with others, eating, hearing, learning, lifting, reaching, reading, seeing, sitting, sleeping, talking, thinking, walking, and writing.*

Please indicate each major life activity/function* that is substantially limited for the student/patient.	**How does the condition substantially limit the major life activity/function in a <u>residential setting</u>?**	**Recommended Housing Accommodation**

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How will the requested housing accommodation mitigate the limitations described above?

What potential adverse effects could result if the requested housing accommodation(s) were denied?

If you are recommending a single room or private living space, please describe any potential risks associated with isolation.

If the recommended housing accommodation is not available, are there alternative accommodations that could address the student/patient's needs? Yes or No (circle)
Please explain:

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Please share any additional information relevant to the accommodation request that you would like CAS to consider.

Provider Name:	License Number/Certification:	Clinic Name:
Phone:	Address:	Fax:

By providing my signature below, I attest that the information included on this form accurately reflects the nature of my relationship with the above-named patient and the above-named patient's diagnosis of a disabling condition that substantially limits one or more of their major life activities.
Provider Signature: _____ Date: _____

This form is for documenting a student's disability in order for the University to determine eligibility for housing-related accommodations. This form does not guarantee the approval of the requested housing-related accommodations. The student must attend a meeting with Campus Accessibility Services to discuss their disability and necessary accommodations. All supporting documentation from the student's provider must be submitted to the University's Campus Accessibility Services (CAS) office for review before accommodations can be determined. The CAS office may contact a student's provider if more information is needed to determine a student's reasonable accommodation.

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