University of Pittsburgh
Johnstown

Office of Disability Services
G-10 Student Union
Phone: 814-269-7119
Fax:814-269-7179

Housing Accommodation Verification Form

Students Please Complete

To request or receive housing accommodations based upon physical or psychological disability; please complete the enclosed specific information regarding your request and the condition(s) for which you are being treated. Students should complete pages 1-2 and your medical provider must complete pages 3-4. This verification form must be completed in its entirety before a request will be given any consideration. All requests for accommodations must be made in a reasonable time frame (3 months prior to arrival).

Student Completes This Section (Please print or type):

Student's Name _____
Last Name First Name

ID Number _____

Date of Birth _____ Gender: _____ Male _____Female

Home Address _____

_____

Home Phone # _____ Cell Phone #_____

Academic year for which you are requesting accommodations _____

On Campus Address *(if assigned)* _____

Cell Phone _____

E-Mail Address _____

Disability_____

Requested Accommodation *(e.g., handicapped accessible room)* _____

_____

_____

_____

Which orientation session will you be attending? (if known)_____

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Authorization to Release and/or Receive Information

I authorize the Director of Disability Services at the University of Pittsburgh at Johnstown and the Director of Housing and Residence Life at the University of Pittsburgh at Johnstown to release and/or receive information from the provider below. I also authorize my provider to discuss my condition(s) with the Director of Disability Services at the University of Pittsburgh at Johnstown and the Director of Housing and Residence Life at the University of Pittsburgh at Johnstown.

Name of Provider: _____

Address (Street, City, State, and Zip Code): _____

_____

Student's Name (please print or type): _____

Student's Signature: _____

Date: _____

ID#: _____

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Medical Provider *Complete & Return to the Office of Disability Services, Pitt-Johnstown,*

Provider Information

NAME OF PROVIDER _____

DATE _____

LICENSE # _____ STATE _____

ADDRESS _____

_____

PHONE # _____ FAX # _____

To determine eligibility for housing accommodations, the University of Pittsburgh at Johnstown requires current and comprehensive information of the student's condition from the diagnosing physician or health care provider (*the provider completing this form should not be a relative of the student*).

1. For what condition are you treating the above referenced student? _____

_____

_____

a. How long has the student had this condition? _____

b. What is the severity of the condition? Please check one:

_____Mild _____Moderate _____Severe

Please explain severity: _____

_____

_____

c. What is the expected duration of this condition? _____

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2. Please state the following:

a. Date of first contact with student _____

b. Date of last contact with student _____

c. Frequency of appointments with student _____

3. List the student's current medication(s), dosage, frequency, and adverse side effects, as they may relate to University housing: _____

_____

4. Describe the functional limitations of the student's condition:

_____

_____

_____

a. Is the requested accommodation:

_____Medically Necessary _____Medically Beneficial *(Please check one)*
Please explain response:

_____

_____

5. Please state specific recommendations regarding housing accommodations for this student. Include a rationale as to why these housing accommodations are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (*e.g., if you suggest a private bedroom, state the reasons for this request related to the students functional limitations and disability*).

_____

_____

_____

_____

_____

Medical Providers Signature **Date**