

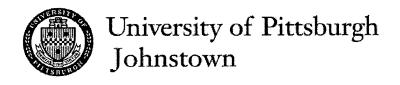
Housing Accommodation Verification Form

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

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's Name	
Last Name	First Name
ID Number	
Date of Birth	MaleFemale
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)



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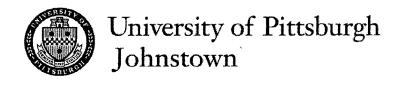
Office of Disability Services **G-10 Student Union** Phone: 814-269-7119

Fax:814-269-7179

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#·	

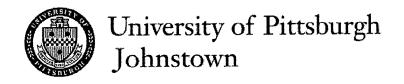


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Housing Accommodation Verification Form

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

Provider Information NAME OF PROVIDER		
DATE		
LICENSE#		
Address		
PHONE #	Fax#	
current and comprehensive information care provider (the provider completing	commodations, the University of Pittsburgh at Johnstown requires on of the student's condition from the diagnosing physician or health a this form should not be a relative of the student). the above referenced student?	
	ad this condition?	
a. How long has the student ha	ad this condition?ondition? Please check one:	
a. How long has the student hab. What is the severity of the c		
a. How long has the student hab. What is the severity of the ca	ondition? Please check one:	
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Medical Providers Signature	Date
111	
rationale as to why these housing accommodimitations. Indicate why the accommodation	egarding housing accommodations for this student. Include a adations are warranted based upon the student's functional are necessary (e.g., if you suggest a private bedroom, the students functional limitations and disability).
a. Is the requested accommodation: Medically NecessaryM Please explain response:	ledically Beneficial (Please check one)
4. Describe the functional limitations of the s	student's condition:
relate to University housing:	
	osage, frequency, and adverse side effects, as they may
c. Frequency of appointments with stu	udent
b. Date of last contact with student	
a. Date of first contact with student	
2. Please state the following:	