Verification Form for Students Requesting Changes to the Housing Environment

Due to a Significant Chronic Physical or Emotional Condition

NOTE: THIS IS ONLY FOR A HOUSING ACCOMMODATION. **It is recommended this form is completed when you complete your housing contract online.**

In order to evaluate how Indiana University can best meet a student's needs for special housing assignment requests, the University requires specific diagnostic information from a licensed clinical professional or health care provider. This professional/ health care provider should be familiar with the history and functional limitations of the student's physical or psychological condition(s). The student must complete section one of the form. This information and the student signature is required so that the appropriate and qualified member of the Indiana University staff (housing assignments, dining, or disability services) has permission to speak with the professional/provider who completes the information in section two to discuss the student's condition or resulting determination. The professional/health care provider must fill out section two, sign, and return the completed packet to the RPS Housing Assignments Office. **Failure to complete both sections completely will result in the form not being reviewed.** The form will be reviewed and the recommendations of the medical provider along with the availability of space that will meet the medical need will be considered.

Mail: **RPS Housing Assignments Office**
801 N. Jordan Ave Room D101
Bloomington, IN 47405

Email: **housing@indiana.edu**

For Spring 2018: Forms submitted before December 1, 2017 will receive priority.
For Fall 2018: Forms submitted before May 1, 2018 will receive priority.
Forms received after this date may not be reviewed.

Please Note: If a student needs academic or other related accommodations, please contact the Disability Services for Students Office at 812-855-7578 or iubdss@indiana.edu .

SECTION ONE

Student fills out the section below. Please print or type.

Student Name: Last: ______________________ First: ______________________ Middle: ______________

Student ID: ______________________ Email: ______________________

Birth Date: ______________________ Gender: Male ☐ Female ☐ Transgender ☐

Home Address: ______________________ City ______________ State ______________ Zip ______________

Home Phone: ______________________ Cell Phone: ______________________

I request consideration for the following term: Fall ☐ Spring ☐ Summer ☐ 20 _____
(circle term and write in year)

I request consideration for the following reason: New Housing Assignment ☐ Room Change ☐
(circle reason for submitting medical information)

Initial Each Statement and Sign

By my signature I:

______ **Acknowledge that my medical condition may impact or limit my housing options, including roommate and location on campus, so that RPS can place me in an assignment that meets my needs. This medical request takes precedent over all other room preferences submitted in my housing application.**

______ Understand that RPS staff may find it necessary to consult with IU Disability Services for Students and/or the IU Health Center about my request and needs, and authorize them to do so in considering my request.

______ Authorize Indiana University to receive information from the medical professional/provider below. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Indiana University personnel on an as needed basis.

Student's Signature: ______________________ **Date:** ______________

Student's Name:____DOB: ______________

To determine special assignment consideration, Indiana University requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). The provider completing this form cannot be a relative of the student. Items 1 thru 4 must be completed in full. 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.

Provider Completes the Section Below. Please respond to the following items in regards to the student named above.

1) Date of Initial Contact with Student: ____________ Date of Last Office Visit with Student:______________

2) What is the student's medical condition/diagnosis (check all that apply)?

Condition	Date of Diagnosis	What is the severity of condition, and how long is the condition likely to persist?
☐ Allergies/Asthma		
☐ Blindness/Visual Impairment		
☐ Deafness or Hard of Hearing		
☐ Diabetes		
☐ Food Allergy		
☐ ADD/ADHD		
☐ Mental Health / Emotional Disorder		
☐ Mobility Limitation		
☐ Other (specify)		

3) Describe the symptoms and state the specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's medical (physical or emotional health) condition. Indicate why the change(s) to the housing environment you recommend are necessary.

4) Describe the current treatment and/or therapy plan.

The provider may also send a report that provides additional related information.

The provider completing this form cannot be a relative of the student.

Signature of Provider:______________________________ Date: ______________

Name:______________________________ Title: ______________

Address: ______________________________ Phone: ______________

License Number:______________________________ State: ______________