Office of Residence Life
University of St. Thomas
3800 Montrose Blvd.
Houston, TX 77006
713-525-3836 ph
713-942-3488 fax
residencelife@stthom.edu

Request for Housing Accommodation

The Office of Residence Life works closely with Counseling and Disability Services to review requests and identify appropriate and available housing solutions for students with documented disabilities and serious medical conditions. Students requesting special accommodation must complete and submit this form in order to receive consideration. *Please note, a diagnosis in and of itself does not automatically qualify for requested accommodation.* It is important this information be received before move-in (i.e. prior to room selection).

***Student Completes This Section (Please print clearly or type)**:*

Name: _____ Male____ Female____
last first middle initial

Student ID#: _____ Date of Birth: _____ Email:_____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

Academic year for which you are requesting accommodation: _____

Name of disability/health condition: _____

Requested housing accommodation: _____

Describe your understanding of your disability/health condition and the impact it might have living on campus:

_____

_____

Describe any adaptive technology, including hardware/software, or specialized equipment that you use:

_____

_____

The information I have provided is accurate to the best of my knowledge. I authorize and consent for the offices of Residence Life and Counseling and Disability Services to consult, as needed with health care providers to clarify documentation and with University personnel on a need-to-know basis.

Student Signature: _____ Date: _____

Student's Name: _____

Health Care Provider Completes This Section:

To determine eligibility for housing accommodation, the University of St. Thomas requires current and comprehensive information of the student's condition from the diagnosing health care provider. ***Please note, the provider completing this form should not be a relative of the student.***

1) Please state the diagnosis(es) for which you are treating this student. (For psychiatric disabilities, include specific DSM-IV-TR diagnosis.): _____

_____

_____

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

_____

b.) How frequently do you have appointments with this student? _____

c.) What is expected duration of condition? Six months_____ One Year_____

More than One Year_____ Lifelong_____

2) Please list the student's current medication(s), dosage and frequency, and any adverse side effects as they may relate to on-campus housing: _____

_____

_____

_____

3) *Please **initial** which major life activities below are affected by the diagnosis, indicating level of limitation*:

Life Activity	**No Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**	**Not Applicable**
Vision					
Hearing					
Speaking					
Mobility					
Self-care					
Eating					
Sleeping					
Memory					
Concentrating					
Managing internal distractions					
Managing external distractions					
Social interactions					
Attending class regularly and on time					
Stress Management					
Organization					

Student's Name: _____

5) Please state specific recommendations for housing accommodations as they relate to the student's diagnosis and functional limitations: _____

_____

_____

_____

Certifying Physician, Clinician or Health Care Provider

Signature of Professional/Date: _____

Name (please print clearly): _____

Professional Title: _____

License#: _____ State: _____

Address: _____

_____

Phone: _____ Fax: _____

This information will be reviewed and accommodation decisions made in accordance with the policies of the University of St. Thomas. For further information or discussion, please contact The Office of Residence Life at 713-525-3836.