

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.