Housing/Dining Accommodation Request Form

Faculty Student Association

of SUNY Adirondack

ADIRONDACK HOUSING ASSOCIATION

Phone: (518) 832-7785 640 Bay Road, Queensbury, NY 12804 Fax: (518) 832-7786

The Adirondack Housing Association (AHA) in conjunction with Accessibility Services at SUNY Adirondack provides students with disabilities equal access to campus facilities and academic programs. If you feel that you are eligible for housing and/or dietary arrangements you must:

1. **complete this form**, and
2. **submit supporting documentation of the condition that is the basis of this request** to the Residence Life Office

Please contact the Residence Life Office with any questions or concerns.

I am requesting: (check all that apply)

 [ ]  Housing Accommodations [ ] Dining Accommodations

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Banner ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment Date: [ ]  Fall 20\_\_\_ [ ]  Spring 20**\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Banner ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOUSING/DINING INFORMATION**

What type of housing and/or meal accommodations do you require?

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Explain how the stated request above relates to your disability:

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Please provide acceptable alternatives if the accommodation is not possible:

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Banner ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION V MEDICAL INFORMATION**

Are you currently under a doctor’s care relating to your request? YES\_\_NO\_\_\_

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking any prescribed medications (housing/dining related)? YES\_\_\_NO\_\_\_

If yes, please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby verify the above information is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please return this form with supporting documentation to*

***The Residence Life Office***

\*\*Forms must be complete in order to be eligible for review\*\*

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# Release and Collection of Disability Related Information

**Authorization to Receive Information:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the Housing/Dining Accommodations Review Committee to receive information from the provider below, specific to this request. I also authorize my provider to discuss my condition(s) with the Director of Accessibility Services. I understand that all documentation is maintained confidentially.

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Attention Provider-** Documentation from your office should be on office letterhead and contain the following information:

1. A clear diagnostic statement including a description of the duration and severity of condition and the current impact of (or limitation imposed by) the disability within the housing setting,
2. A statement regarding treatments or services used to minimize the impact of a disabling condition,
3. Recommendations for accommodations that are reasonable and validated by current documentation.
4. The name, title, address and phone number of certifying professional(s) including date of diagnosis and/or evaluation.