CSB/SJU Student Accessibility Services
37 S College Ave
St Joseph, MN 56374

Housing Accommodation Documentation Form

The student named below is requesting accommodations due to the impact of a disability. To evaluate that request, Student Accessibility Services requires additional information completed by a qualified professional, who: 1) has first-hand knowledge of the student's condition and 2) is an impartial individual not related to the student.

The provision of reasonable accommodations is determined on a case-by-case basis, following a Welcome Meeting with the student, and the review of supporting documentation from a treating practitioner. This documentation, which is used to determine accommodation eligibility, must describe the current impact of the disability on academic performance or experience outside of the classroom. Please be advised that accommodations are made to ensure access to educational opportunities for students with disabilities, not to make adjustments that would lower standards or fundamentally alter the nature of academics or programs.

This completed form can be returned via:
Fax: (320) 363-6097
Mail: Student Accessibility Service, HAB 105, 37 S College Avenue, St. Joseph MN 56374

AUTHORIZATION TO RELEASE INFORMATION I AUTHORIZE:

- My provider to provide the information below to Student Accessibility Services. This includes mental health information,
- My provider to discuss my condition, with Student Accessibility Services, if more information is necessary beyond this form.
- Student Accessibility Services to receive information from the provider below.

Student Name_____ Date of Birth: _____

Provider Name: _____Clinic: _____

Student Signature: _____Date: _____

Certifying Professional (To be completed by the qualified professional)

Name (Please Print): _____

Professional Title: _____

License/Certification Number and Issuing State(s): _____

Clinic/Agency Name: _____

Address: _____

City: _____ **State**: _____**Zip Code**: _____

Phone: _____**Fax**: _____

Verification of Disability:

Accommodations are available to students identified as having a disability. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

> **Examples of major life activities**: major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Based on this definition noted above, does the individual you are treating have a disability?

☐ yes ☐ no ☐ Not able to answer.

Based on your professional scope, can you confirm whether the student meets any of the following disability categories: Choose all that apply to the student's disability:

☐ Deaf/hard of hearing	☐ Physical Disability	☐ Speech/Language impairment
☐ Blind/visually impaired	☐ Mental/Psychiatric	☐ ADD/ADHD
☐ Learning disability	☐ Autism Spectrum	☐ Brain Injury
☐ Systemic Disability	☐ Other (please specify): _____	

State the student's primary diagnosis and secondary diagnosis/es with corresponding ICD-10 codes:

_____

_____

Did you diagnose this individual with the abovementioned condition(s)? ☐ Yes ☐ no

Date of Diagnosis: _____ Date of your most recent evaluation: _____

Is your principal clinical relationship to the student associated with the diagnoses and/or treatment of the disabling condition for which the student bases the request? ☐ Yes ☐ no

Indicate your role in the student's health care management process (check all that apply):

☐ Primary Care/Family Physician
☐ Single Session Provider
☐ Counselor/Psychotherapist
☐ Psychiatrist
☐ Crisis Intervention/Trauma Therapy
☐ File Review
☐ Other: _____

Are you a relative or close friend of the student and/or family? ☐ yes ☐ no

The prognosis for the medical condition or disability above is:

☐ Permanent/Chronic Long-term: 6-12 months
☐ Short-term/Temporary: 6 months or less
☐ Episodic (please describe below) Expected duration: _____

Life Activity	Limitation on function	Degree of limitation:
☐ Activities of daily living		☐ Mild ☐ Moderate ☐ Severe
☐ Ambulation		☐ Mild ☐ Moderate ☐ Severe
☐ Breathing/Respiratory		☐ Mild ☐ Moderate ☐ Severe
☐ Climate/Environment		☐ Mild ☐ Moderate ☐ Severe
☐ Communication/Social Interaction		☐ Mild ☐ Moderate ☐ Severe
☐ Eating		☐ Mild ☐ Moderate ☐ Severe
☐ Endurance		☐ Mild ☐ Moderate ☐ Severe
☐ Manual Dexterity		☐ Mild ☐ Moderate ☐ Severe
☐ Motor Coordination		☐ Mild ☐ Moderate ☐ Severe
☐ Operations of bodily functions		☐ Mild ☐ Moderate ☐ Severe
☐ Self-care		☐ Mild ☐ Moderate ☐ Severe
☐ Sleeping		☐ Mild ☐ Moderate ☐ Severe
☐ Speaking		☐ Mild ☐ Moderate ☐ Severe
☐ Stress Management		☐ Mild ☐ Moderate ☐ Severe
☐ Other:		☐ Mild ☐ Moderate ☐ Severe

Additional Comments/Questions:

Describe how the functional limitations mentioned above might impact the student in a college residence:

_____

_____

_____

_____

identify any measure(s) (e.g., medication, treatment, therapy) the student is using that mitigates the limitations caused by his/her impairment:

_____

_____

_____

Describe specific recommendations you believe are medically necessary, based on the student's functional limitations. Please explain how they are essential for the student's ability to access, use and enjoy their dwelling:

_____

_____

_____

_____

Add any additional information you believe is important in our consideration of residential accommodations for the student:

_____

_____

_____

_____

All recommendations are considered. Potentially effective alternatives may be considered as needed. Decisions are made based on the nature of the disability and functional limitations, reasonableness of the request, timeliness of the request and available housing.

Health Practitioners Signature: _____ **Date**: _____

Please return this form, along with any supporting documentation to:
CSB/SJU Student Accessibility Services CSB HAB 105
37 S College Ave
St. Joseph MN 56374
Phone: 320-363-5245
Fax: 320—363-6097

***In addition to this verification form, please attach or provide any information that you feel is relevant in determining appropriate accommodations for this student.