

## REQUEST FOR DISABILITY RELATED HOUSING ACCOMMODATIONS

### Treating Practitioner's Disability Verification Form

Otterbein University is a residential campus that values the social development and academic success that coincide with the residential experience. We will engage in a process to offer solutions for on-campus residence life accommodations necessitated by a disability. Medical documentation and preferences will be taken into consideration during that process but may not be equal to the final solutions offered by the university as appropriate on-campus accommodations meant to fulfill the disability-related need. Our goal is to ensure that all students have the ability to safely and substantially attend classes, live on campus, and abide by university policy.

Otterbein University provides reasonable accommodations to persons with disabilities who have a verifiable need for the reasonable accommodation because of a disability as defined by the Americans with Disabilities Act (ADA) Section 12102. A reasonable accommodation is an exception to the usual rules or policies that a person with a disability needs because of their disability to have an equal opportunity to use and enjoy Otterbein University owned housing.

Documentation must be provided by a licensed or credentialed professional, with specific training or expertise related to the condition being diagnosed, who has diagnosed or is currently treating the student. This request form must be fully legible for processing. Please feel free to attach a typed page with each numbered response.

#### AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (Student completes)

*I authorize my provider listed below to release health care information to Otterbein University. Furthermore, I authorize my provider to discuss my condition(s) with the appropriate and qualified Otterbein University personnel on an as needed basis.*

Provider Name: \_\_\_\_\_ Provider Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Code

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Otterbein Student ID: \_\_\_\_\_ Class year: FR SO JR SR

**Parent/Legal Guardian signature is required if the student is under 18 years of age.**

Parent/Legal Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### TO BE COMPLETED BY TREATING PRACTITIONER

Today's Date: \_\_\_\_\_

For purposes of this verification, **a disability is defined as a physical or mental impairment with an actual or expected duration longer than 6 months that substantially limits one or more major life activities or major bodily functions as compared to most people in the general population.**

1. Does this person have a disability under this definition? Yes No

2. Please identify the disability and the diagnostic code(s) of the condition(s) (e.g. DSM-V or ICD-10).

\_\_\_\_\_

3. Date of last clinical contact with student related to this disability: \_\_\_\_\_

4. Has this disability impairment lasted for more than 6 months? Yes No (If no, please explain expected length of disability impairment.)

\_\_\_\_\_

5. Please indicate the level of impact the student’s disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Attending class regularly					
Caring for oneself					
Communicating					
Concentrating					
Hearing					
Interacting with others					
Interacting socially					
Learning					
Making/keeping appointments					
Managing distractions					
Managing stress					
Meeting deadlines					
Memorizing					
Organization					
Performing manual tasks					
Reading					
Seeing					
Sleeping					
Thinking					
Writing					

6. Please describe how the student’s disability impairment substantially limits their ability to perform a major life activity or bodily function as compared to most people in the general population:

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7. What reasonable accommodation **is essential** to allow the student to use and enjoy campus housing?

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8. Please describe the identifiable relationship between the accommodation recommendation and the disability impairment (how will the student’s disability impairment be improved by the essential accommodation?).

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**MEDICAL/HEALTHCARE PROVIDER INFORMATION**

**THIS SECTION MUST BE COMPLETED, SIGNED OR STAMPED WITH PROVIDER’S OFFICE INFORMATION**

*The provider completing this form cannot be related to the student*

**I certify, by my signature below, I diagnosed or am currently treating the student named above.**

Provider’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

State of License: \_\_\_\_\_ License Number: \_\_\_\_\_

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

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

**Return form DIRECTLY to:** Tracy Benner, Director of Residence Life    Fax: 614-823-3299