



## *Office of Academic Development*

### ***Disability Support Services – Knight Hall***

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### **Verification of Physical or other Medically-related Disability (Housing)**

To ensure the provision of reasonable and appropriate services and/or accommodations for students with medical or physical disabilities at Arcadia University, a physician who is qualified to diagnose the disability must provide current and comprehensive documentation of the student's medical or physical disability.

For those students with **AIR CONDITIONING REQUESTS**; AU requires a letter from the student's specialist; i.e. allergist or pulmonologist, that specifies exactly why student requires an air conditioned room. Every attempt will be made to ensure student has an air conditioned room if medically appropriate. **Prescriptions or documentation from primary doctor will NOT be honored.**

For those students with **SINGLE ROOM REQUESTS**; AU requires documentation that justifies the medical necessity of a single room. Examples of medical necessity may include: presence of 24/7 personal care attendant, self catheterization, need to store a power chair, etc. While it may not be a medical necessity to have a single room, students with disabilities may be given a single room preference due to their disability when available and will be charged the single room rate.

All contact information and documentation is kept in a separate, private file within the Office of Academic Development, Disability Support Services. No information about accommodations or documentation will be released or discussed without written consent from the student.

Please fax or mail the completed form to us. Our contact information is above.

**NAME OF STUDENT:**

**TODAY'S DATE:**

Medical Diagnosis:

Date of Diagnosis:

Is the patient/student currently under your care?

When did you last see the patient/student?

What procedures were used to diagnose the condition? Please attach evaluation results, if available.

Please describe the present symptoms of this condition.

Is the student currently taking medications for this condition?

If yes, please list.

Please describe (briefly) the effects of these medications.

If the student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

What are the necessary accommodations?

Please indicate of the level of need for the recommended housing configuration (and consequences of not receiving this specific configuration)

Please describe the specific functional limitations resulting from the impact of this disability on the student's housing or non-academic life (physical facilities)?

**Life Activity – Functional Limitations**

Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.

Sleeping

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Eating

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Social Interactions

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Self-Care

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Attending class regularly and on time

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Stress Management

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Organization

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

Other (please specify): \_\_\_\_\_

No Impact    Minimal Impact    Moderate Impact    Substantial Impact    Uncertain

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Are the functional limitations permanent?

If not, what is the expected timeline for resolution?

Are the functional limitations degenerative?

If so, what significant consequences might impact the student in a post-secondary setting?

Please describe or attach any additional information that you believe to be relevant to the student's disability-related academic needs.

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date.

CERTIFYING MEDICAL PROFESSIONAL:

Signature of Medical Professional	Date
Printed Name and Title	License #
Address	Telephone Number
City, State, Zipcode	

If you have any questions, please feel free to call.

**Please return this form to:**

Arcadia University  
Office of Academic Development – Disability Support Services  
Knight Hall  
450 S. Easton Road  
Glenside, PA 19038  
Fax: 215-517-3124