Student Name:_____**Andrew ID:**_____

Carnegie Mellon University

Office of Disability Resources

University Housing Accommodation Application:

Healthcare Professional Supplement

Section 1: University Housing Accommodations Application: Authorization to Release Information (To be completed by the Student)

Completing this section will authorize the Office of Disability Resources or other Carnegie Mellon employees acting on behalf of the Office of Disability Resources to contact your diagnosing/treating professional to discuss any questions or request clarification.

Authorization to Release Health Care Information: I authorize the provider listed below to release information related to my request to the Office of Disability Resources, for the purpose of an accommodation to my housing assignment because of a disability or chronic health condition; And to discuss this request with the Office of Disability Resources, if necessary. Information released could include my diagnosis, functional limitations, treatment history, and/or prognosis.

Name of medical or mental health professional: _____

Title of medical or mental health professional: _____

Address of medical or mental health professional:

_____

_____

City: _____ State: _____ ZIP: _____

Phone #:_____ Fax #: _____

To be signed by the student if age 18 or older. To be signed by parent/legal guardian if student is not yet 18 years old.

Signature:_____Date: _____

Student Name:_____ **Andrew ID:**_____

Section 2: University Housing Accommodations Application: Healthcare Professional Supplement

(To be completed by the Licensed Medical or Mental Health Professional)

To ensure that the Office of Disability Resources can make an informed decision on the student's requested housing accommodations, Disability Resources requires documentation from a licensed medical or mental health professional who has been treating the requesting student. Please answer the following questions as completely as possible. In addition to completion of this document, please submit documentation on official letterhead listing your specialty, licensure information, the date that you last saw the requesting student, and your signature. For the purposes of this document, "disability" is understood as a physical, sensory, cognitive, or psychological impairment that substantially limits one or more major life activities.

1. Student's diagnosis/es related to their disability:

   _____

   _____

2. When was the condition first diagnosed: _____

3. Please describe the severity of the diagnosed condition:

   _____

   _____

   _____

   _____

4. What treatment or medications have been prescribed and/or recommended to address the diagnosed condition?

   _____

   _____

   _____

5. What treatment have you provided (please include start and end dates)? Is treatment ongoing?

   _____

   _____

   _____

6. Please explain how the student's diagnosed condition substantially limits any major life activities:

   _____

   _____

   _____

   _____

7. Please state specific recommendations for housing accommodations that this student needs and explain why these accommodations are medically necessary given their diagnosed condition and

associated disability. (Note: If requesting a single room, please indicate whether the student can share communal living space and/or bathroom with others in the dormitory generally or with roommates/suitemates. If student cannot share communal living space and/or bathroom, please explain why not.)

_____

_____

_____

8. How did you derive these recommendations? Please check all that apply:

Student's or parent's request for specific accommodation

Clinical assessment to determine need for accommodation

Mutual agreement determined through discussion between clinician and student

Other_____

Signature:_____ Date: _____

Name:_____

License number: _____

Area of specialty: _____

Date of last visit: _____ Phone:_____ Fax: _____