



COMMUNITY LIFE (HOUSING) DISABILITY FORM
SPARTANBURG METHODIST COLLEGE | ACCESSIBILITY RESOURCES

Student's Name: _____

SMC ID Number: _____ Student's Cell Number: _____

Student's Email: _____

Please check your class:

___ Freshman

___ Sophomore

___ Junior

___ Senior

Today's Date: _____

What housing-related accommodations are you requesting?

Empty box for housing-related accommodations.

TO BE COMPLETED BY MEDICAL OR TREATING PROFESSIONAL

Medical or Treating Professional's Name:

Empty box for Medical or Treating Professional's Name.

What is the student's diagnosis/disability?

Empty box for student's diagnosis/disability.

What is the date of your first appointment with this student?

Empty box for date of first appointment.

What is the most recent date of your appointment with this student?

Empty box for most recent appointment date.

What methods of evaluation were used to make the diagnosis?

Empty box for methods of evaluation.

What are the symptoms/effects of the student's diagnosis/disability?

Empty box for symptoms/effects of diagnosis.



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What Community Life (Housing) accommodations are you recommending for this student?

How will the requested accommodations alleviate the symptoms or effects of the diagnosis/ disability?

Is the requested accommodation a necessity for the student's health or well-being?

Yes No
 Other (Please Explain):

Will this student need assistance with evacuating the Community Life building in the event of an emergency? Please explain:

I attest that this information is accurate and complete to the best of my knowledge. I also attest that I am not related to the student by blood or through marriage.

Medical or Treating Professional's Signature: _____

Date: _____