SMC STAR

RESIDENCE LIFE HOUSING-RELATED DISABILITY FORM

Student's Name: ____

SMC ID Number: ____

Student's Cellphone Number: _____________________________________

Student's Email: ____

Please check your class:

___ Freshman ___ Sophomore

___ Junior ___ Senior

Today's Date: _____________________

What housing-related accommodations are you requesting? _______________

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____

TO BE COMPLETED BY MEDICAL OR TREATING PROFESSIONAL

Medical or Treating Professional's Name: ________________________________

What is the student's diagnosis/disability? _______________________________

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

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

What methods of evaluation were used to make the diagnosis? _________________

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

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What Residence Life accommodations are you recommending for this student?

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

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____

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 Resident Life building in the event of an emergency? Please explain:

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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 with by blood or through marriage.

Medical or Treating Professional's Signature:

____

Date: ____