Disability Accommodation Request Form

Student ID# ______________________________ Class Status: FR SO JR SR other: ______________________

Student Name: __________________________________________ ________________________________

Address: __________________________________________ _________________________________________

Contact # ________________________________ Alt. Contact # ______________________________

Chapman University Email Address: _______________________________________________________

I am requesting accommodation for: __________________________ Semester/Year

Please complete and submit this form and the REQUIRED letter\(^1\) from your health care provider.\(^2\) Letters from health care providers must be current\(^3\) and address the needs you have for a special accommodation in the housing environment. For your convenience, you may use the attached Letter to Health Care Providers, which may be found on the Chapman University Residence and First Year Experience website at: http://www.chapman.edu/studentLife/resLife/forms.asp.

To conduct a full review and evaluation of this request, the University requires a letter from your current licensed health care provider. The letter from your health care provider must include:

1. A detailed description of current functional limitations of the disability (a listing of the diagnosis is not required and will not substitute for the detailed description of functional limitations);
2. A statement of whether the limitations are permanent or temporary, an if temporary, the expected duration;
3. A description of how the limitations and support a need for a special housing accommodation;
4. Specific suggested accommodations and a list of possible alternative accommodations;
5. Credentials of the diagnosing professional including contact information; and
6. A statement that the physician is not a family member or personal friend of the patient.

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\(^1\) Letter must be a typewritten letter from a licensed health care provider appearing on the professional letterhead stationery of the provider and dated. Notes on prescription pads are not acceptable for the process.

\(^2\) Health care provider must be a qualified licensed professional that specializes in the area of the condition or disability and who is not a family member or personal friend of the requestor.

\(^3\) Generally, current documentation is considered to be no more than 6 months old for psychological disabilities and no more than 12 months old for all other disabilities.
While the Residence Life and First Year Experience respects the private nature of medical records and the laws governing those records, for housing accommodation requests to receive every consideration, it is sometimes necessary to contact the health care provider. If this becomes necessary, we will use the release provided below should you choose to sign the release. Please know that some health care providers have another preferred format for a release. If the health care provider does not accept the release below, you will be notified and it shall be your responsibility to contact the health care provider and arrange for a release.

If you choose not to provide any of the items listed or authorize contact with the health care provider, there may not be sufficient information available for the University to conduct a review which may result in insufficient information for the University to adequately review and evaluate the request for accommodation.

Authorization to Receive Disability-Related Medical Information

I authorize Chapman University Residence Life and First Year Experience Accommodations Committee to receive information from the licensed professional below. I authorize the licensed professional below to discuss my disability and limitations with the Chapman University Residence Life and First Year Experience Accommodations Committee.

Name of Licensed Professional: ________________________________

Address of Licensed Professional: ________________________________

Telephone Number of Licensed Professional: _________________________

Name of Student/Patient (please print): ______________________________

Signature of Student/Patient: ________________________________

Date: ______________________________
Dear Health Care Provider:

I am requesting a housing accommodation at Chapman University.

In order to conduct a full review and evaluation of this request, the University requires a dated, typewritten letter on the letterhead stationery of my current licensed health care provider that describes the limitations of my condition or disability and supports my request for a special housing accommodation.

The letter must include all of the following:

• A detailed description of current functional limitations of the disability (a listing of the diagnosis is not required and will not substitute for the detailed description of functional limitations);

• A statement of whether the limitations are permanent or temporary, and if temporary, the expected duration;

• A description of how the limitations and support a need for a special housing accommodation;

• Specific suggested accommodations and a list of possible alternative accommodations;

• Credentials of the diagnosing professional including contact information; and

• A statement that the physician is not a family member or personal friend of the patient.

Additionally, I ___have ____ have not (please check one) authorized Chapman University Residence Life and First Year Experience Accommodations Committee to contact you directly should they need additional information or clarification in consideration of my request.

Please send all the relevant information to:

Chapman University
Residence Life and First Year Experience Office
One University Drive
Orange, CA 92866

All requests will be reviewed and evaluated by the professional staff serving on the Residence Life and First Year Experience Accommodations Committee. All information provided will be held in the strictest of confidence and in compliance with applicable statutory medical records requirements and will only be shared with those professionals necessary to fully evaluate the request.

Signature: ________________________________

Printed Name: ________________________________

Date: ________________________________