Documentation for Accommodation Requests

University Student Housing, LLC is committed to supporting individuals with disabilities through reasonable accommodations.

This form and accompanying documentation should be submitted to request a disability-related accommodation.

1. The student completes the top portion of the form below.

2. The student, or their parent/legal guardian if under the age of eighteen (18), must fill out and sign the Authorization of To Release Form below. This signature provides permission for the health care provider/professional to do the following:

   a. Complete the information requested on this form, and

   b. Speak with representative from USH Affiliated Housing who is reviewing your ADA accommodation request.

3. The health care professional/provider must fill out the remainder of this form and sign it. The professional/provider must be thoroughly familiar with the student's disability or medical condition(s) and resulting functional limitations and/or restrictions. Please note: We require that the professional/provider completing these forms is not a family member through blood, marriage, or other legal arrangement.

USH Accommodation Request Contact Information:
Email Option – admin@ushcommunities.org

Mail Option:
University Student Housing, LLC.
Attn: ADA Coordinator
715 S. New St.
West Chester, PA 19383

Student fills out the section below. Please print or type.

Student Name (First, Last): _____
Address:_____
Phone:_____ **Email:**_____

Term Session This Request Applies to (check one): □ **2024-2025 Academic Year** □ **2025-2026 Academic Year**

RamNet ID: _____ **Class Year:**_____

Academic Classification (*Circle one)*: First Year Sophomore Junior Senior Graduate

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I authorize the provider listed below to release information and medical records related to my request to University Student Housing, LLC for the purpose of an accommodation to my housing assignment because of a disability, and to discuss this request with a representative of University Student Housing, LLC, if necessary.

Name of Provider: _____

Specialty: _____

Address (Street, City, State and Zip): _____

_____

Accommodation for a student's housing assignment because of a disability or chronic health condition supersedes all other requests, including roommates.

I have read and understand the above information.

Student's Signature

_____Date _____

Parent/ Legal Guardian Signature, if student is under 18

_____Date _____

Medical/Health Care Provider Completes and Signs Section Below

STUDENT'S NAME:_____

Provider Completes the Section Below:

To consider this student's request for an accommodation because of a disability/chronic health condition in his/her housing assignment, **Undergraduate Housing requires documentation of the student's current medical condition and medical records** from the treating and licensed clinical professional or health care provider thoroughly familiar with this student's condition and his/her functional limitations and/or restrictions. Items 1 through 4 must be completed in full. If the spaces provided are not adequate, please attach a separate sheet of paper.

Please respond to the following items regarding the student named above:

1) Does the student's disability/health condition significantly limit any major life activities? If yes, please describe the limitations and/or restrictions in detail. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2) When was the student last seen by you?_____
_____
_____

3) Please state specific recommendations regarding the accommodation(s) this student needs in their housing assignment **AND** explain why such an accommodation is warranted, based upon the student's physical or psychological condition(s). _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4) For how long do you consider the information you provide in Items 1-3 above to be valid without reassessment and/or updated information?

[ ] The circumstances described in this form are **permanent and stationary**

[ ] The circumstances described in this form may not be permanent or stationary, but I expect no significant change through_____, _____
Month Year

All fields below must be complete to process

Signature of Provider:_____

Date:_____

License # and state and/or other pertinent credentials:

_____

_____

Print Name & Title:

_____

Address

_____

_____

_____

Phone _____

Fax _____
