Housing Accommodations Request Form

In order to request an accommodation for your on-campus housing assignment, please complete this form in its entirety. This form must be submitted directly to: Counseling & Accommodation Services Center, Attn: Eric Petersen, Champlain College, P.O. Box 670, Burlington, VT 05402. Forms may also be sent via email to epetersen@champlain.edu.

The Counseling & Accommodation Services Center at Champlain College evaluates requests for housing accommodations for students on behalf of the Department of Residential Life. Documentation must substantiate a diagnosed impairment that is a current substantial limitation to a major life activity as it relates to housing needs. To ensure provision of reasonable and appropriate accommodations for students, this office and the Department of Residential Life require current and comprehensive documentation of the disorder from a current treatment/assessment professional who is legally qualified to make the diagnosis.

The Housing Accommodations Request Form MUST BE SUBMITTED EACH YEAR for review and renewal of appropriate accommodations related to Residential Life. Only students who have been notified they have received permanent disability-related housing accommodations are exempt from completing section B of this form.

This form is submitted as a:

___ NEW Request

Please complete Sections A and B.

___ RENEWAL of a Previous Request

If updated documentation was requested in your disability-related housing accommodations approval letter, please have Section B completed by a certified treatment professional and submit the updated form for review.

DEADLINES: Students admitted for August—form is due June 01. / Students admitted for January—form is due December 15.

SECTION A | NEW REQUESTS ONLY

Are you currently registered with the Office of Disability Services and have you already provided documentation that specifically addresses housing accommodations? Yes ____ No ____

SECTION B | DOCUMENTATION

The following information MUST be completed by a CERTIFIED TREATMENT PROFESSIONAL

Student Name ________________________________ Date of Birth: ________________________________

Street Address __________________________________________________________

Phone Number __________________________________________________________

1. DSM IV/ICD 9 Diagnosis: ________________________________________________

Date of Diagnosis ________________________________ Date of Last Contact with Student ________________________________

2. Please describe symptoms that meet the criteria for this diagnosis and report evaluation and assessment results:

   A. Severity _____________________________________________________________

   B. Duration ___________________________________________________________

   C. Expected Long-term Impact ___________________________________________

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3. What instruments, test/assessments, diagnostic procedures were used to diagnose the medical condition? Please attach relevant results (i.e. audiogram, functional capacity evaluations, diagnostic test results, etc.).

4. Describe prognosis (short/long term) for this condition: 


5. Please list his/her current prescribed medication(s), dosage, frequency and possible adverse side effects as they may relate to the need for college residential housing accommodations: 


6. Please describe how this disorder exhibits itself as a current substantial limitation to a major life activity in a college residential/housing environment: 


7. Please list the recommendations you have for housing accommodations that would help this student access the college residential environment: 


PLEASE NOTE: The Counseling & Disability Services Center will not accept disability-related documentation from treatment professionals who are related, in any way, to the student requesting services. In order to provide the appropriate analysis to documentation received, the Counseling & Accommodation Services Center must be able to rely on the treatment professionals with the highest capacity for objectivity.

Signature __________________________ Date __________________________

Print Name and Title __________________________

Address __________________________

Phone __________________________

The information that you provide is maintained in the Counseling & Accommodation Services Center according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).