Documentation of Disability/Medical Condition
for Housing Accommodations Request

Note: Lourdes University is committed to providing its students with a comprehensive educational experience. The Residency Requirement is a part of our commitment to the growth and development of our students inside and outside the classroom. As such, we endeavor to accommodate students disabilities/medical conditions within university housing. Students with disabilities/medical conditions that cannot be accommodated by Lourdes residence halls may be exempt from the Residency Requirement.

Student Name: _____

Medical/Health Care Provider: The above person is a current or entering student at Lourdes University and is requesting accommodations on the basis of a disability and/or medical condition. To consider this student's request for an accommodation, Lourdes University requests documentation of the student's disability/medical condition 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. Please complete this form in its entirety. If the spaces provided are not adequate, please attach a separate sheet of paper. This information is kept confidential at the highest level possible.

Is the student currently under your care? ____Yes ____No

If yes, for how long have you cared for the student?_____

Diagnosis: _____

Date of Diagnosis/Diagnoses: _____

Date of last visit for this condition: _____

Severity of the condition (check one): ___Mild ___Moderate ___Severe

Please list any current treatment, medications and side effects:

What factors exacerbate this condition?

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

Please state specific recommendations regarding the accommodation(s) this student needs in relation to the classroom/campus/residence hall environment and explain why such an accommodation is warranted, based upon the student's limitation(s).

Anticipated duration of need for accommodation(s):

If you are related to this student, what is your relationship?

Physician's Signature; _____ Date: _____

Physician's Name: _____ Specialty: _____

License/Cert. # _____ State: _____

Address: _____

Phone: **Fax:**

Information may be forwarded to:
Office of Accessibility Services, Lourdes University
DEH 105, 6832 Convent Blvd, Sylvania, OH 43560
Fax: 419-517-7458; Phone: 419-824-3523; Email: oas@lourdes.edu

Please note: General notes or statements without a specific diagnosis history, severity level, limitations, signature, and appropriate provider credentials will not be accepted. Additionally, documentation statements from clinician parents/relatives will not be accepted.

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