



Petition for Housing Accommodation

To request or receive housing accommodations for a medical reason or a documented disability at Washington & Jefferson College, you must submit information regarding your request and the condition for which you are being treated. Students MUST complete page one, and medical providers MUST complete the remaining pages and submit on your behalf. **(Your medical provider can not be a family member and must be the specialist you are working with in regards to your specific request or need).** The verification form must be completed in its entirety before a request will be reviewed. By submitting this paperwork you authorize College medical staff to cross reference this information with your medical provider if necessary. **Medical Providers MUST** Mail or fax (724-229-5143) completed materials and any supplemental materials:

*Office of Residence Life
Washington & Jefferson College
60 South Lincoln Street #3020
Washington, PA 15301*

Student Completes this Section (Please Print or Type):

Class Year: _____ Residence Hall and Room #: _____ Birth Date: _____

Gender (circle): Male Female

Home Address: _____

Home Phone #: _____ Cell Phone #: _____

Requested Accommodation (i.e. handicapped accessible room):

I authorize the provider listed here and in the subsequent documentation to release confidential information related to my medical housing accommodation request to the Office of Housing & Residence Life at Washington & Jefferson College. I also give my provider permission to discuss my condition with this office. This information will be made available to Washington & Jefferson College faculty and staff only on a need-to-know basis.

Name of Provider: _____

Provider's Phone #: _____

Student Printed Name

Date

Student Signature

Date

Medical Diagnosis Verification Form

Medical Provider Please Complete (Please print or type, if form is illegible it will be returned to the student)

Date of Completion of Form _____/_____/_____

Provider Name: _____

License #/State: _____

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

Phone #: _____ Fax #: _____

To determine eligibility for medical housing accommodations, Washington & Jefferson College requires current and comprehensive information on the student's condition from the diagnosing physician or health care provider.

Client's Name: _____

Date of initial contact with student: _____/_____/_____

Medical Diagnosis:

Date of Diagnosis: _____/_____/_____

Describe symptoms associated with this medical condition: _____

Date of Last Contact with Student : _____/_____/_____

What is the severity of the condition? *Please check one:* Mild () Moderate () Severe ()

Please explain severity: _____

What is the expected duration of this condition? _____

Frequency of appointments with student: _____

List current medications including dosage and side effects: _____

Long-term medication plan: _____

Current compliance with medication plan: _____

Prognosis for medication plan (include likelihood of improvement or deterioration and within what timeframe):

Impact of condition on residential success. Please identify the specific major life activities that are compromised by the condition cited above. Indicate severity of these limitations.

Suggested Accommodation: _____

Why is this particular style of housing needed? _____

**In your professional opinion, is the requested accommodation
() medically necessary or () medically beneficial? (please check one)**

Please explain response: _____

I verify that the medical information listed above is accurate and true.

Physician Printed Name: _____ Physician Signature: _____

Submit to:
Office of Residence Life
60 South Lincoln Street #3020
Washington, PA 15301.
Fax: 724-229-5143
Phone: 724-229-5120
E-mail: reslife@washjeff.edu