

## Professional Request for Information for Housing Accommodations

### Top portion to be completed by student:

1. Student Name: \_\_\_\_\_
2. Student ID Number (if known): \_\_\_\_\_ Student Date of Birth: \_\_\_\_\_

I request that the information from my health care professional be used in support of my request for a housing accommodation. I understand that this documentation will be reviewed by the Monmouth College Accessibility Services Review Committee. Furthermore, I give my consent to any member of the Accessibility Services Office to contact my health care professional for additional information as needed.

3. Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### To be completed by requesting the student's physician/clinician.

Psychiatric disabilities should be documented by a psychologist, psychiatrist, counselor, or other professional trained and licensed to treat and diagnose these conditions. Monmouth College retains the right to request additional documentation if needed to determine appropriate accommodations. This form must be completed in full and signed. If the spaces provided are not adequate, please feel free to respond to the questions on letterhead and submit with the remainder of the form completed.

4. Federal law defines a person with a disability as "any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment, or is regarded as having such an impairment." Please respond to the following items regarding the student named above:

- a. Does the student have an impairment that substantially limits any major life activities? If yes, please describe the limitations and/or restrictions in detail.

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- b. How long has the student been under your care? When was the student/patient last seen by you? \_\_\_\_\_

5. Please indicate which of the following housing accommodations you suggest based upon the student's condition:

\_\_\_ Wheelchair-accessible room/building

\_\_\_ Wheelchair-accessible shower/bath

\_\_\_ Kitchen access

\_\_\_ Non-communal bathroom

\_\_\_ Strobe alarm

\_\_\_ Vibration alarm

\_\_\_ Single Room

\_\_\_ Other

6. Please describe specifically why the suggested accommodations are necessary:

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7. Provider contact information, signature, and date of form. Provider, please send it back via email to [access@monmouthcollege.edu](mailto:access@monmouthcollege.edu), by fax to 309-457-2213, or mail to: Monmouth College, Accessibility Services, 700 E Broadway St, Monmouth, IL 61462. Thank you for your time.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email address: \_\_\_\_\_

License #: \_\_\_\_\_

Signature of Professional \_\_\_\_\_