Accessibility Resource Center
~Ensuring Access, Supporting Success

Send information to:
Erin Bain MEd
Thiel College
Accessibility Resource Center
75 College Avenue
Greenville, PA 16125
Fax: 724-589-2249

REQUEST FOR HOUSING ACCOMMODATIONS
PROFESSIONAL FORM-MEDICAL A/C

To be completed by a licensed professional (see below). Please provide responses to the following items by typing or writing clearly. Illegible forms will delay the documentation review process for the student. Upon completion, the form may be faxed to the Accessibility Resource Center at 724-589-2249, mailed to Thiel College at the above address or emailed to EBain@thiel.edu or accessibilityservices@thiel.edu**.**

TO BE COMPLETED BY STUDENT:

NAME	STUDENT ID:
DOB:	YEAR IN COLLEGE:
LOCAL PHONE:	CELL PHONE:
ADDRESS:	

TO BE COMPLETED BY PROVIDER:

The requested documentation is necessary to help determine reasonable accommodation. Appropriate and complete documentation by a medical professional is required. The information provided will be part of the student's confidential file in the Accessibility Resource Office. **This form must be completed on a yearly basis**. Accommodations are by availability of current equipment.

1. Please describe the student's disability/health condition. Include DSM or medical diagnosis and date of most recent evaluation:

2. Conditions that require medical air conditioning:

3. Additional comments/relevant information supporting the need for requested accommodation:

I give permission to the Accessibility Resource Coordinator to contact the above listed person to obtain any additional information if needed. I understand there is an additional charge of ***$300.00*** *for an air conditioner in my room per year (fall and spring semester) if medical documentation is not received in the Accessibility Resource Office* ***by June 15th of the fall semester.***

Student's Signature: **Date:**

The professional should also send any reports that provide additional related information. The professional completing this form cannot be a relative of the student. The professional signing this form must be the same person answering the questions on the form above.

Professional's Name (please print)	
Title:	License #:
Address:	
Phone:	Email:
Signature of Professional:	**Date:**

Examples of Acceptable Professional Diagnosticians:

Disability:	**Diagnostician(s)/Provider(s):**
ADD, ADHD	Psychologist, Psychiatrist, LPC, LSW, LCSW
Emotional Disability	Psychologist, Psychiatrist, LPC, LSW, LCSW
Visual Impairment	Ophthalmologist
Hearing Impairment	Certified Otologist, Audiologist
Learning Disability	Psychologist, Neuropsychologist, School Psychologist
Physical Disability	Physician, Nurse Practitioner