Housing/Dining Accommodation Request Form

FACULTY STUDENT ASSOCIATION
of SUNY Adirondack
ADIRONDACK HOUSING ASSOCIATION

Phone: (518) 832-7785 640 Bay Road, Queensbury, NY 12804 Fax: (518) 832-7786

The Adirondack Housing Association (AHA) in conjunction with Accessibility Services at SUNY Adirondack provides students with disabilities equal access to campus facilities and academic programs. If you feel that you are eligible for housing and/or dietary arrangements you must:

1. **complete this form**, and
2. **submit supporting documentation of the condition that is the basis of this request** to the Residence Life Office

Please contact the Residence Life Office with any questions or concerns.

I am requesting: (check all that apply)

☐ Housing Accommodations ☐ Dining Accommodations

Name: ________________________________ Date: ____________________

Address: ____

City: ______________________________ State: _______ Zip __________

Home Phone: __________________ Alternate/Cell Phone: ________________

E-Mail Address: ____

Date of Birth: _________________

Banner ID # __________________

Enrollment Date: ☐ Fall 20___ ☐ Spring 20___

Name: ___________________________________ Banner ID # ____________________

HOUSING/DINING INFORMATION

What type of housing and/or meal accommodations do you require?

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Explain how the stated request above relates to your disability:

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Please provide acceptable alternatives if the accommodation is not possible:

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Name: ___________________________________ Banner ID # ____________________

MEDICAL INFORMATION

Are you currently under a doctor's care relating to your request? YES__NO___
If yes, please explain:

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Are you taking any prescribed medications (housing/dining related)? YES___NO___
If yes, please specify:

____
____

I hereby verify the above information is true and accurate to the best of my knowledge.

Signature: ____

Date: ___________________________

Please return this form with supporting documentation to
The Residence Life Office

Forms must be complete in order to be eligible for review

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Release and Collection of Disability Related Information

Authorization to Receive Information:

I, _________________________, authorize the Housing/Dining Accommodations Review Committee to receive information from the provider below, specific to this request. I also authorize my provider to discuss my condition(s) with the Director of Accessibility Services. I understand that all documentation is maintained confidentially.

Name of Provider: ____________________________

Provider Phone: ____________________ Provider Fax: ________________

Provider Address:

____

(Street)

_______________________ _________ _____________

(City) (State) (Zip Code)

Student Signature:______________________________

Date:____

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Medical Provider: Supporting Documentation

Attention Provider- Documentation from your office should be on office letterhead and contain answers to the following questions:

1. **What is the nature of the student's long term, permanent, or serious medical condition? Please provide pertinent background information related to the student's disability.**
2. **How long have you been working with the student regarding this diagnosis?**
3. **Please provide evidence of the connection between the diagnosis/symptoms and the requested accommodation to treat or manage symptoms.**
4. **What evidence is there that the student will not be able to use and enjoy the residence hall or participate in its services or programs if the accommodation is not allowed?**
5. **Can you recommend alternate accommodations?**

Failure to answer and acknowledge the above questions may result in the following:

1. **Requests for further documentation from the medical provider**
2. **Denial of requested accommodation**