



Nichols College  
*Learn. Lead. Succeed.*

## New Student HOUSING ACCOMMODATION REQUEST FORM

The following information is required before any housing accommodation request can be processed.

The priority deadline for this document is July 5th 2025 at 3pm for Fall/Spring housing 2025-2026. Requests after this date will be reviewed on a first come basis, and based on remaining space.

Any and all supporting documents must be attached/included. Students MUST reapply for accommodations each year by the deadline with updated medical information.

**\*\*This request MUST be returned to the Office of Student Life, Fels 301\*\***

**Email-jessica.ryan@nichols.edu, Phone-508-213-2480 (No Fax)**

Student Name (Please Print) \_\_\_\_\_ Student ID# \_\_\_\_\_

**This request is:**

- A first time request
- A renewal of a previously granted request with **no changes**. If there are no changes, completing Part 2 is not necessary.
- A renewal of a previously granted request with changes or additions
- A second request for a previously denied request

**Please identify your documented disability. Check all that apply:**

- Learning Disability (Please specify)
  - \_\_\_\_\_
- Attention Deficit/Hyperactivity Disorder
- Chronic Medical Condition (Please specify)
  - \_\_\_\_\_
- Food Allergy (Please specify)
  - \_\_\_\_\_
- PDD/Asperger's Syndrome
- Physical/Mobility Impairment
- Psychiatric/Psychological Disability
- Neurological (Please specify)
  - \_\_\_\_\_
- Communication/Speech Impairment
- Visual Impairment or Blindness
- Deaf or Hearing Impairment
- Acquired or Traumatic Brain Injury
- Temporary Injury/Condition
- Other (Please specify)
  - \_\_\_\_\_

**Describe the impact of your disability on a major life activity:**

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**Please list the accommodation(s) you are requesting:**

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**Please describe how your disability requires special accommodations to promote success while residing in a residential environment:**

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**I authorize the provider listed below to release information related to my request to the Nichols College Office of Residence Life and Health Services for the sole purpose of an accommodation to my housing assignment due to a disability or ongoing medical need, and to discuss this request with a representative, if necessary.**

**Name of Provider that has diagnosed or is currently treating condition(s)** \_\_\_\_\_

**Specialty** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

- I verify that the information contained within this document is accurate to the best of my knowledge
- I understand that a housing accommodation because of a disability or chronic health condition supersedes all other requests including roommate and certain building requests
- My documentation may be shared with the appropriate staff in order to support my accommodation

*The Director of Health Services and the College Physician will review this request. As such, I hereby authorize Nichols College Health Services to release any pertinent information contained within my health record concerning the above request to Residence Life and Dean of Students offices. I understand that falsifying College documents is a Code of Conduct Violation which carries significant sanctions and could jeopardize my student status.*

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*Student Signature*

*Date*

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*Student Name (Printed)*

*Nichols ID#*

**Part 2-TO BE COMPLETED BY PHYSICIAN who is treating condition(s):**

**Student Name (Please Print)** \_\_\_\_\_

**Diagnosis in the area(s) of:** \_\_\_ Psychiatric \_\_\_ Physical \_\_\_ Medical \_\_\_ Learning

**Date last seen by your office relative to the disability in question:** \_\_\_\_\_

**When was the disability first diagnosed:** \_\_\_\_\_ **By whom:** \_\_\_\_\_

**Evaluation method(s) used:** \_\_\_\_\_

**Severity of current symptoms:** \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe

**Condition is:** \_\_\_ Stable \_\_\_ Prone to Exacerbation \_\_\_ Permanent/Chronic \_\_\_ Temporary

**What is the nature of the student's disability? Describe impact of disability on major life activity.**

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**What is the student's treatment plan and how does this Housing Request play a part in an on-going treatment plan?**

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**Briefly describe the likely impact of the disability on the student's ability to live in campus housing:**

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**Please state the specific recommendations regarding the accommodation(s) this student needs in their housing assignment. Indicate why the accommodation is warranted based on the student's disability. If the space provided is not adequate, please attached additional pages typed on your letterhead.**

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**Is the accommodation request:** \_\_\_ Essential \_\_\_ Beneficial but not essential \_\_\_ Not Essential

**Please explain:**

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*It may be helpful to note that due to the nature of living in a residence hall community, a request for a quiet hall is not a medical accommodation that can be met. Additionally, because a residence hall is shared by hundreds of students participating in various activities throughout the day, living in a single room does not necessarily provide a student with a quiet, distraction free environment.*

Does the student's disability require any medical devices or equipment? If so what is the size, dimension, special needs of the equipment (wattage, etc.).

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I verify that the above-named student information is correct, and that the student is a patient that I have been treating, and that I am not a relative of the student.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

License # \_\_\_\_\_ State \_\_\_\_\_

Name and Title \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Email \_\_\_\_\_