Office of Residence Life

Nichols College

STUDENT HOUSING & DINING ACCOMMODATION REQUEST FORM

Students requesting housing or dining accommodations related to a disability or medical condition should complete the required request form and provide supporting documentation as needed. Each request is reviewed individually based on the student's disability-related needs.

Renewals/Previously Approved Accommodations: Students must renew their accommodation request each academic year. Updated medical documentation is generally not required if the previously approved accommodation and disability-related need have not changed. Additional information may be requested when necessary to review a renewal request.

Section I – Student Information – to be completed by the student:

Student Name (Please Print): _____

Student Nichols Email: _____

Student ID: _____

Date of Request: _____

Please identify the type of disability or condition related to your accommodation request. Check all that apply:

- ☐ Attention Deficit/Hyperactivity Disorder (ADHD)
- ☐ Autism Spectrum Disorder
- ☐ Chronic Medical/Health Condition
- ☐ Food Allergy or Dietary-Related Condition
- ☐ Learning Disability
- ☐ Mental Health/Psychological Disability
- ☐ Neurological Condition
- ☐ Physical/Mobility Disability
- ☐ Sensory or Communication Disability
- ☐ Temporary Injury/Condition
- ☐ Other: _____

Please list the accommodation(s) you are requesting:

_____
_____
_____
_____
_____

Describe how your disability impacts you within a residential and/or dining environment.

_____
_____
_____
_____
_____
_____
_____

What barrier(s) do you anticipate experiencing in campus housing and/or dining because of your disability?

_____
_____
_____
_____
_____
_____
_____

Explain how the accommodation(s) you are requesting would reduce or remove those barriers.

_____
_____
_____
_____
_____
_____
_____

Sections II & III (pages 3–4) must be completed by a qualified provider only.

Section II – Medical Information – to be completed by the qualified provider:

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

Primary Diagnosis: _____

Secondary Diagnosis: _____

When was the condition first diagnosed: _____

Condition is: ____Stable ____Prone to Exacerbation ____Permanent/Chronic ____Temporary

Course of Treatment (ex: medications prescribed, specialty referrals, etc.)**:**

_____
_____
_____

Please check the major life activities that are substantially limited by the condition:

Walking		**Hearing**		**Seeing**		**Self-Care**	
Reading		**Working**		**Learning**		**Breathing**	
Lifting		**Eating**		**Sleeping**		**Concentration**	
Speaking		**Thinking**		**Standing**		**Communicating**	
Performing Manual Tasks		**Operation of Bodily Functions**		**Other:**			

Please describe the student's disability-related functional limitations that are relevant to the housing and/or dining environment. Identify any environmental features that may reduce or remove these barriers and explain how each feature relates to the student's functional limitations.

_____
_____
_____
_____
_____
_____
_____

Briefly describe the likely impact of the disability on the student's ability to live in campus housing and/or their ability to access or utilize the College's dining program.

_____
_____
_____
_____
_____
_____
_____

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.

Section III – Provider Information – to be completed by the qualified provider:

Name of Provider: _____

Specialty and License #: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

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.

Provider's Signature _____ **Date** _____