



Office of Residence Life

Nichols College

STUDENT HOUSING & DINING ACCOMMODATION VERIFICATION FORM

Students requesting housing or dining meal plan accommodations must submit all required information and supporting documentation before their request can be processed. Updated medical documentation is required each year, and students must reapply by the stated deadline through the [Student Housing & Dining Accommodation Request Form](#).

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

Student Name (Please Print) _____**Student ID#** _____**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)
 - _____

Please list the accommodation(s) you are requesting:

Section II – Provider Information – to be completed by provider who is treating condition(s):

Name of Provider: _____

Specialty and License #: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Section III – Medical Information – to be completed by provider who is treating condition(s):

Diagnosis in the area(s) of: ____Psychiatric ____Physical ____Medical ____Learning**Primary Diagnosis:** _____**Current Severity Level:** ☐Mild ☐ Moderate ☐ Severe**Secondary Diagnosis:** _____**Current Severity Level:** ☐Mild ☐ Moderate ☐ Severe**When was the disability first diagnosed:** _____ **By whom:** _____**Date of last clinical visit related to diagnosis:** _____**Evaluation method(s) used:** _____**Condition is:** ____Stable ____Prone to Exacerbation ____Permanent/Chronic ____Temporary**Course of Treatment** (ex: medications prescribed, therapies tried, specialty referrals, etc.):

What is the nature of the student's disability and how does this request play a part in an on-going treatment plan?

Please check the major life activity(ies) that are substantially limited by the disability:

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 your recommendations for necessary accommodations. Please include a rationale and explain how each accommodation would mitigate a functional limitation of the student's underlying condition.

If the space provided is not adequate, please attached additional pages typed on your letterhead.

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

Is the request: ☐ Essential ☐ Beneficial but not essential ☐ Not Essential
Please explain:

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.

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** _____

Office of Residence Life

Email: reslife@nichols.edu | Phone: 508-213-2092 (+FAX) | Office: Fels Student Center 301
[For more information visit our: Housing and Dining Accommodations Page](#)