Center for Health and Wellbeing
Housing Modification Request Form

This form can be used to request a housing modification or a housing contract release, based on a medical condition not covered by the ADA laws.
For more information about this form, visit our website: www.uvm.edu/health.

Section I:
To be completed by the student.
Student Name: _______________________________________ UVM Student ID: ____________________________
Phone Number: ______________________________________  Email:  ______________________________________
Briefly describe your request. We will contact you to gather more information if needed.
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Section II:
To be completed by current primary care/other medical professional.
A letter and/or encounter note from the professional is also acceptable.

1. ICD-9 Diagnosis:  _______________________________________________________________________
2. Date of Diagnosis:  ______________________________________________________________________
3. Last Contact with Student:  ______________________________________________________________________
4. Please provide description, severity, and duration of symptoms that meet criteria of diagnosis:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
5. Please provide description of prognosis (short/long term) for this condition:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
6. Please list all current prescribed medication(s) for this condition:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
7. How does this condition affect the individual’s ability to participate in residential life at UVM?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

CHWB must be able to rely on the professional credentials and objectivity of medical or treating professionals when making decisions about student housing needs. Generally, documentation should be from a medical/treatment professional who is not directly related to the student. The University reserves the right to request additional or independent medical evaluation if the documentation received does not indicate that the medical/treatment professional is objective or the information received does not provide adequate information.

Medical Provider Information:

Signature: ____________________________________________ Date: ________________

Print Name and Title: ______________________________________________________________

Address: __________________________________________________________________________________

City: ___________________________ State: _______ Zip Code: _________________________

Phone Number: ____________________________________________________________________________

Send this form, and any accompanying documentation to:

UVM Student Health Center

c/o Anne Desmond, RN

425 Pearl Street

Burlington VT 05401

Fax: (802) 656-8178