Verification form for Disability-Related Housing Accommodations

The University of Vermont (UVM) supports students seeking accommodation for disabilities, including disability-related housing accommodations. Student Accessibility Services at UVM, strives to insure that qualified students with disabilities are accommodated in a manner that supports therapeutic treatment.

First- and second-year students are required to live on campus for four semesters as full-time students. Students who wish to receive disability-related housing accommodations must have this form completed by a qualified health care provider, which may be a certified physician, other diagnosing medical professional, or specialist (such as, but not limited to: an MD, audiologist, neurologist, endocrinologist). The individual completing this form must have first-hand knowledge of the student's condition and will be an impartial professional who is not related to the student.

Once this completed form is received, the student will be notified if their request is either approved or not as reasonable and appropriate.

This form should be returned to Student Accessibility Services via mail, email or fax.

Student Accessibility Services
Center for Academic Success
633 Main Street
A170 Living/Learning Building
The University of Vermont
Burlington, VT 05405-0365
Phone: (802) 656-7753
Fax: (802) 656-0739
Email: access@uvm.edu
Office Hours: Monday through Friday from 8:00 A.M. to 4:30 P.M
Student Information (This section to be completed by the student)

Permission to release information to the University of Vermont

Name: (please print) __________________________  Date: __________________________

Signed: _____________________________________  UVM Student #: 95 ________________

Phone/Email: ________________________________

Please indicate what semester/year this accommodation is for: ___________________________

Please describe your specific and essential housing accommodation request: __________________________

___________________________________________________________________________________

Specify the medical or psychological disability and how it impacts you in a student housing situation.

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

****TO BE COMPLETED BY A CERTIFIED PROFESSIONAL*****

VERIFICATION OF DISABILITY-RELATED NEED FOR HOUSING ACCOMMODATIONS

To be completed by the current diagnosing professional (please type or print legibly):

1. What are the diagnosis, severity, and diagnostic criteria/tests used? __________________________
2. What are the dates of the most recent evaluation and last contact? __________________________
____________________________________________________________________________________
_____________________________________________________________________________________

3. What is the expected duration of this condition? _________________________________________
____________________________________________________________________________________
_____________________________________________________________________________________

4. Please describe current treatments and/or medications currently prescribed.
____________________________________________________________________________________
_____________________________________________________________________________________
____________________________________________________________________________________
_____________________________________________________________________________________

5. How does this disability impact the student’s ability to function effectively in the residence hall?
____________________________________________________________________________________
_____________________________________________________________________________________
____________________________________________________________________________________
_____________________________________________________________________________________

6. Are there any situations or environmental conditions that might lead to exacerbation of the condition?
____________________________________________________________________________________
_____________________________________________________________________________________
____________________________________________________________________________________
7. The following housing accommodations are essential: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

8. Please explain the health impact if the essential housing accommodations are not met.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Name: ___________________ Credentials: ____________________________________________

License/Certification number and state of licensure: ____________________________

SIGNATURE OF CERTIFYING PROFESSIONAL ___________________ DATE __________

Name of Certifying Profession: (please print): __________________________________________

Street Address
____________________________________________________________________________________

Address (City, State, Zip)
____________________________________________________________________________________

Email Address
____________________________________________________________________________________

This document may not be released without written permission from the student or by order of a court. It will be destroyed seven years after the student is no longer enrolled at the University.