# REQUEST FOR DISABILITY RELATED HOUSING ACCOMMODATIONS

BUFFALO STATE
The State University of New York

**Step 1.** Students requesting related housing accommodations must complete **Section I** of this form, **Student Information** and **Provider Authorization**.

**Step 2.** Please have the medical or mental health provider who is most familiar with your history, functional limitations, and the impact your disability as it relates to living in the residence halls complete **Section II. Section II** should be completed in full, legible, and signed. **This section cannot be completed by the student or a family member**.

## SECTION I

STUDENT INFORMATION

**Name**

**Last:** **First:** **MI:**

**Banner ID: B00** _____ **Email Address:**_____**@mail.buffalostate.edu**

**Home Address:**_____

_____

**Local Address:** _____

**Phone Number:** _____

**Type of Request:** (Please specify. Use additional paper if necessary)

_____ Specific Room Type or Location _____

_____ Emotional Assistance Animal_____

_____Residence Hall Fixtures, Equipment, etc._____

_____Other (please specify):_____

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## Provider Authorization:

I authorize Buffalo State College to receive information supporting my housing accommodation requests from the following provider:

**Provider Name:**_____ **Area of Practice:**__

**Address:**_____ **Phone:**_____

**Student Signature:**_____ **Date:**_____

**Would you like SAS and Residence Life staff to be able to speak with a parent or family member regarding this request?**

**Yes/ No (please circle)**

**Name of Parent/Family member:** _____

**Please Return Form To:**

Student Accessibility Services
Buffalo State College
1300 Elmwood Ave
South Wing 120
Buffalo, New York 14222-1095

Email: Sas@buffalostate.edu
Fax: 716 878-3804

## SECTION II

**To Be Completed By A Medical Or Mental Healthcare Provider:**

*In order to provide reasonable and appropriate disability related housing accommodations, Buffalo State College requires documentation for the medical or mental health professional who is most familiar with your disability. The professional completing this form should not be a family member and must be knowledgeable of your current functional limitations and how your disability impacts you in a campus living setting.*

1) What is the student's medical condition/diagnosis?_____

_____

_____

_____

_____

a) How long has the student had the condition(s)?)_____

b) What is the severity of the Condition (s)?_____

_____

c) How long is the condition(s) likely to persist? _____

2) What are the functional limitations as a result of this diagnosis (how does the condition substantially limit a major life activity in the college setting?)

_____

_____

_____

3) What type of disability related housing accommodation is the student requesting?

_____

_____

a) Please state the rationale as to why housing accommodations are necessary or why the change(s) to the student's current housing are necessary (e.g., if a single room or living off campus is suggested, state the reasons related to the student's condition for their request):

**MEDICAL/MENTAL HEALTH CARE PROVIDER INFORMATION**
**THIS SECTION MUST BE COMPLETED SIGNED OR STAMPED WITH PROVIDER'S OFFICE INFORMATION**

Provider Name/Title (please print):

Address: Phone Number:

Provider's Signature: Date:

License Number: State:

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