

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 Ro	oom Type or Location						
Emotiona	l Assistance Animal						
		nt, etc					
other (pleas	.c 3pccii y /						



Provider Authorization:

provider:	ing my nousing accommodation requests from the following
Provider Name:	Area of Practice:
Address:	Phone:
Student Signature:	Date:
Would you like SAS and Residence Life staff to be able to spea 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

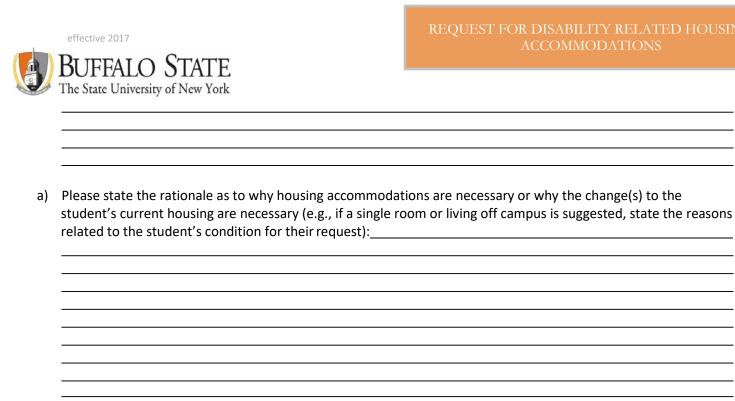


SECTION II

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?				
		, 5			
	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)		nat are the functional limitations as a result of this diagnosis (how does the condition substantially limit a jor life activity in the college setting?)			
3)	Wł	nat type of disability related housing accommodation is the student requesting?			



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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