

**Housing Accommodation Verification Form**

This form should be completed by the designated qualified professional.

Student/Patient's Name:

How long have you been working with the student/patient?

Please specify the student's disability and the date of diagnosis.

If applicable, please rate the level of severity of the student's diagnosis.

- Mild  Moderate  Severe

Duration of condition:  Permanent  Temporary (specify length of time):

How did you arrive at your diagnosis? Please check all relevant items below.

- Behavioral Observations/Development History  Structured/unstructured student interviews  
 Medical History  Psycho-Educational Testing  
 Rating Scales  Neuro-Psychological Testing  
Date(s) of Testing: \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_  
Date(s) of Testing: \_\_\_\_\_

Please indicate the level of impact the student/patient's disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	Don't Know
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating/Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing stress and emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking or climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing manual tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the major life activities marked to have a moderate or substantial impact, please provide an explanation of how the student's functioning is impacted in campus housing.

Please list any accommodations or modifications you are recommending to Alfred University's campus housing or policies. Describe how each recommended accommodation or modification will impact the student's symptoms and/or functioning.\*

If applicable, please describe the relevant history of remediation (e.g., other treatment plans and their effectiveness).

*\*Accommodation recommendations will be considered in the interactive process. However, final accommodation decisions will be determined by Alfred University's Disability Housing Committee.*

### HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name & Credentials:

Phone #:

License or Certification #:

Address:

Provider Signature:

Date:

**Please mail completed forms to:**

The Center for Academic Success · Alfred University  
1 Saxon Drive · Alfred, NY 14802  
Phone: 607-871-2148 · Email: CAS@alfred.edu · Web: my.alfred.edu/cas