ENDICOTT COLLEGE

Housing Accommodations
Disability Documentation Form

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

Endicott College is deeply committed to the full participation of students with disabilities in all aspects of College life. As a four-year residential college, learning to live in a community and share space with others is an integral part of students' educational experience.

Accommodations in the residential environment are not granted based on preference or a desire for a particular type of location or for a desire for a quiet, undisturbed place to study, but rather when determined that a standard residential assignment is not a viable option for this student.

Student's Name:		**Date of Birth:**	

This form is to be completed by a qualified health care provider (who is not related to the student) with experience and expertise regarding the functional limitations of the student's disability and current symptomology that would impact the student's housing needs. Thank you in advance for providing as much detail possible in your responses.

Care Provider Information		Practice Name and Address (Stamps welcome)
Provider Name:		
Credentials:		
Email:		
Telephone:		

The student named above has requested a disability-based accommodation at Endicott College. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities." Examples of major life activities are listed in Item 3, below. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

1. **Under the ADA, this individual has a…** *(please select)* ☐ **Disability** **or** ☐ **Temporary Impairment**
2. **Please cite the student's diagnosis:**

Dx #1:	Diagnostic code:	
Dx #2	Diagnostic code:	
Dx #3	Diagnostic code:	

From the:

☐ **DSM-IV-TR** ☐ **DSM-V** ☐ **ICD-9** ☐ **ICD-10**

3. **Please check the major life activity(ies) that are substantially limited by the disability/impairment:**

☐ walking	☐ hearing	☐ seeing	☐ manual tasks
☐ reading	☐ working	☐ learning	☐ breathing
☐ lifting	☐ eating	☐ sleeping	☐ concentration
☐ speaking	☐ thinking	☐ standing	☐ communicating
☐ bending	☐ self-care	☐ the operation of major bodily functions	
☐ other:			

4. **Date of diagnosis:** **Made by you?** ☐ **Yes**
☐ **No, Dx made by:**

5. **Number of consultations with you in the past 3 years:** **Date of your most recent evaluation:**

6. **Length of time under your care:**

7. **Currently under your care?** ☐ **Yes** ☐ **No, care ended on:**

8. **Medical/therapeutic equipment needed:**

9. **Describe any relevant side effects of prescription medication(s):**

10. **Please describe in detail the symptoms currently experienced by the student**.

11. **Please describe in detail how the disability interferes with one or more major life activities as would be encountered in the residential living environment**. *(Attachments welcome if additional space is needed.)*

12. **Please indicate the approximate frequency of symptoms experienced:**

☐ periodic - # of annual occurrences: ☐ ☐ X per month ☐ most days

☐ seasonal - # of annual occurrences: ☐ ☐ X per week ☐ daily

How long do symptoms persist?

Other/Comments?

13. **Please describe and provide rationale for any modifications you are recommending to accommodate the student's disability. Please also explain how the modifications you recommend would assuage the functional limitations of the student's underlying condition.**

14. **What are some possible alternatives if meeting your primary recommendation is not possible?**

15. **Accommodations for this condition are recommended…**

- ☐ For several months… How many? ☐
- ☐ for the duration of the student's time in college
- ☐ For the next year
- ☐ duration is unknown at this time

Other/Comments:

16. **If you are recommending a single room, please indicate whether and how there are any risks associated with isolation:**

17. **Please indicate whether and how this student may be at risk during an emergency evacuation *(e.g. fire)*:**

18. ☐ **I have attached the supporting documentation for this diagnosis.** _____

Please print and manually sign here

Care Provider's Signature **Date**

This completed form is not to be given to the student. It should be sent directly to Endicott.

Thank you for printing, signing and returning this form to Endicott's Center for Accessibility Services as soon as possible via:

Email: access@endicott.edu

Fax: 978-338-0643

US Mail: 376 Hale Street, Beverly, MA 01915

Questions? Call: 978-998-7769