



Petition for Housing Accommodation

To request or receive housing accommodations for a medical reason or a documented disability at Hilbert College, you must submit information regarding your request and the condition for which you are being treated. Students MUST complete page one, and medical providers MUST complete the remaining pages and submit on your behalf. **(Your medical provider cannot be a family member and must be the specialist you are working with in regards to your specific request or need).** The verification form must be completed in its entirety before a request will be reviewed. By submitting this paperwork you authorize College staff to reference this information with your medical provider if necessary. **MEDICAL PROVIDERS MUST MAIL COMPLETED MATERIALS AND ANY SUPPLEMENTAL MATERIALS TO:**

*The Office of Accessibility Services
Hilbert College
5200 South Park Avenue
Hamburg, NY 14075*

Student Section (Please Print):

Academic Year: _____ Birth Date: _____

Gender: Male Female

Home Address: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Requested accommodation and reason for request:

I authorize the provider listed here and in the subsequent documentation to release confidential information related to my medical housing accommodation request to the Director of Academic & Accessibility Services and/or the Director of Counseling at Hilbert College. I also give my provider permission to discuss my condition with these offices. This information will be made available to Hilbert College faculty and staff on a need-to-know basis only.

Furthermore, Residence Life holds the right to charge students based on the type of room received. Students who request a single room will be charged the single room rate. Students who request a double for themselves and a care attendant will be charged two times the double room rate. The Office of Residence Life holds the right to change the prices of housing, and grievances about cost should be addressed with Residence Life.

Name of Provider: _____

Provider's Phone: (_____) _____ - _____

Student Name Printed

Date

Student Signature

Date

Medical Diagnosis Verification Form

Medical Provider Section ***(Please print or type)***

Date of Completion of Form _____

Provider Name: _____

License # /State: _____

Address (Street, City, State, and Zip): _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

To determine eligibility for medical housing accommodations, Hilbert College requires current and comprehensive information on the student's condition from the diagnosing physician or health care provider.

Client's Name: _____

Date of initial contact with client: _____

Medical Diagnosis:

Date of Diagnosis: _____

Describe symptoms associated with this medical condition:

Date of Last Contact with Student: _____

What is the severity of the condition? *Please check one:* Mild () Moderate () Severe ()

Please explain severity:

What is the expected duration of this condition?

Frequency of appointments with student:

List current medications including side effects:

Client's compliance with medication plan:

Impact of condition on residential success. Please identify the specific major life activities that are compromised by the condition cited above. Indicate severity of these limitations.

**In your professional opinion, is the requested accommodation
() medically necessary or () medically beneficial? (Please check one)**

Please explain response:

I verify that the medical information listed above is accurate and true.

Physician Printed Name: _____

Physician Signature: _____

Submit to:
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Hilbert College
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Hamburg, NY 14075*