Disability Resource Center **Housing & Residential Life**

Housing Accommodation Request and Verification Form

For Students Requesting Housing Accommodations
due to a Significant Physical, Medical, Psychological or Sensory Disability

Directions: To request or receive housing accommodations, students must register with the UNLV Disability Resource Center (DRC). In order to evaluate how the University can best meet a student's need for housing accommodation, the University requires specific diagnostic information from a qualified, licensed professional or health care provider. This professional/provider should be familiar with the history and functional limitations of the student's condition(s). The student should complete pages one to two of the form below. The entire form should be given to the health care professional/provider to complete the remaining pages. This verification form must be completed in its entirety before a request will be given consideration. Return the completed packet to the UNLV Disability Resource Center.

Mail: University of Nevada, Las Vegas
Disability Resource Center
4505 S. Maryland Parkway, Box 452015
Las Vegas, NV 89154-2015

Fax: 702-895-0651
Phone: 702-895-0866
Campus Location: SSC-A 143

Student Completes This Section - Please Print or Type

Student Name: _____
(Last) (First) (Middle)

MyUNLV User ID: _____ Date of Birth: _____

Rebelmail: _____ Phone Number: _____

Semester(s) for which you are requesting accommodation: (Check all that apply)
☐ Fall 20 ____ ☐ Spring 20 ____ ☐ Summer 20 ____

What is the nature of your condition?

Do you have documentation on file with the Disability Resource Center that supports your specific housing needs? ☐ Yes ☐ No

Please indicate below the specific accommodation(s) that you are requesting:

☐ Wheelchair Accessible Unit
☐ Central Location
☐ Single Room in Suite
☐ Shower Chair/Bench
☐ Amplified telephone/text telephone
☐ Special Dietary requirements
☐ Other: _____
☐ Low Closet Shelves
☐ Ground Floor
☐ Roll-in Shower
☐ Grab bars in Bathroom
☐ Visual Alert System (fire, door knock, bed shaker)
☐ Meal Plan Adjustment

Please check any equipment you will bring which relates directly to your disability:
(Include measurements on large items)

□ Manual Wheelchair	□ Shower Chair	□ Hospital Bed
□ Electric Wheelchair	□ Refrigerator	□ Hoya Lift
□ Motorized Scooter	□ Bed table	□ Oxygen Machine

□ Other, please describe briefly: _____

Do you require the use of a service animal? □ Yes □ No

Will you need the assistance of an overnight Personal Care Attendant*? □ Yes □ No
If yes, please describe needs below

Please explain details of an emergency backup plan if you are without an attendant

***** A Personal Care Attendant (PCA) is not a support that the University is required to provide. The DRC works with students who require a PCA. However, the sole responsibility of obtaining and employing a PCA is that of the student. The cost and maintenance of services for a Personal Care Attendant remain the responsibility of the student.

STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION
(Print or Type)

Name (Last, First, Middle): _____

Date of Birth: _____ MyUNLV User ID: _____

Local phone: _____ Cell phone: _____

UNLV Rebelmail Address: _____

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize the UNLV Disability Resource Center to communicate with the named individual or Healthcare Provider identified below to obtain clarification, as needed, to determine my eligibility for housing accommodations, due to a disability, at UNLV. In order to implement housing accommodations, some information may be shared with staff of UNLV Housing and Residential Life. This authorization is valid for six months.

Student's Signature: _____ Date: _____

Medical/Health Care Provider Completes This Section - Please Print or Type

STUDENT'S NAME: _____

To determine eligibility for changes to the housing environment, the University of Nevada, Las Vegas Disability Resource Center requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). Please corroborate the need for the housing accommodations requested by this student on the previous pages. Include a rationale as to why these housing needs are warranted based upon the student's functional limitations. Indicate why the change(s) to the housing environment you recommend are necessary. (e.g. if you suggest a private bathroom, state the reasons for this request related to the student's functional limitations and disability).The provider completing this form cannot be a relative of the student. **Items 1 thru 10 must be completed in full.** If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

Please respond to the following items regarding the above named student:

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

   Level of severity: □ Mild □ Moderate □ Severe

   Duration: □ Temporary □ Permanent □ Chronic/Recurring □ Episodic

   Date of diagnosis: _____

   Date of initial contact with student: _____

   Most recent contact with student: _____

2. Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

3. Major Life Activities Assessment:

   Please check which of the following major life activities listed below are affected because of the impairment. Please indicate the severity of the limitations.

Life Activity	1. Negligible	2.. Moderate	3. Substantial	Don't Know
Talking				
Hearing				
Breathing				
Standing				
Caring for Oneself				
Reaching				
Lifting				
Sitting				
Walking				
Seeing				
Writing				
Performing Manual Tasks				
Sleeping				
Learning				
Reading				
Thinking				
Concentrating				
Memorizing				
Interacting with Others				
Other:				
Other:				

4. Describe the functional limitations of the student's condition as they may relate to campus housing.

5. How will the student manage these symptoms in other campus environments (e.g. dining hall, library, computer labs, classrooms)?

6. For episodic conditions, how frequent are the episodes, and what is their duration?

7. List the student's current medication(s), dosage, frequency and adverse side effects.

8. Are there any significant limitations to the student's functioning directly related to the prescribed medications?
   □ Yes □ No If yes, please describe:

9. Is the requested accommodation ( ) medically necessary or ( ) medically beneficial? (Check one.)
   Please explain response:

10. Describe *possible alternatives* that could be considered if the preferred accommodation is not available.

The provider may also send a report that provides additional related information.

The provider completing this form cannot be a relative of the student.

Signature of Provider: _____ Date: _____

License #: _____ State: _____

Please Print

Name/Title: _____

Address: _____

Phone: _____ Fax: _____