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

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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: ___________________________