SACRAMENTO STATE

California State University, Sacramento
Disability Access Center
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Housing Accommodation Medical Provider Form

Instructions: Students requesting housing accommodations for North Village, a residential education community at Sac State should complete section 1 of this form and provide it to their qualified medical provider. The qualified medical provider should complete section 2. The completed form can be submitted to the Disability Access Center by the student.

The student named below may be eligible for services offered through the Disability Access Center at Sac State. To assess whether the student qualifies for such services, information is needed about the student's functional limitations that affect living in a residential education community. Please be assured that the information provided will be used in confidence for the educational benefit of the student. The Disability Access Center at Sac State reserves the right to make final determination concerning the eligibility, approval, and continuation of accommodations and services.

Section 1

Student Name:

Date of Birth:

Sac State ID:

I authorize my medical provider and/or medical records department to release the requested health information and as needed additional clarification relevant to the impact of my disability in educational settings.

Student Signature:

Date:

Section 2

THE FOLLOWING IS TO BE COMPLETED BY A QUALIFIED MEDICAL PROFESSIONAL

Date of initial Patient/Client Relationship:

Date of last office visit prior to completing this form:

1. Please list any medical conditions that you diagnosed and/or are treating associated with the need of a housing accommodation:

Diagnosis	Date of Diagnosis	Severity of Functional Limitation			Permanent or Temporary	Date of Last Treatment
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		

2. What assessments or instruments were used to determine the student's diagnosis(es)?

3. For any diagnosis(es) where the functional limitation is indicated as "severe," please answer the following:
What is significant about the student's condition and/or symptoms that severely impacts major life activities, and how was the severity determined?

4. Please list any medications that you have prescribed:

Medication / Auxiliary Aid	Frequency	Side Effects

5. What major life activities are affected by the student's condition?

6. What type of housing accommodations are needed to address, eliminate, or reduce the impact of the student's disability-related symptoms?

7. Please describe the nexus between the requested housing accommodation(s), the major life activities, and the student's disability-related symptoms.

8. Provide information about secondary/alternative housing accommodation recommendations should any of the requested accommodations not be available.

Information about Qualified Medical Provider

Name:

Specialty:

Licensure Type:

License Number:

State Issued:

Expiration Date:

By completing and signing this form, I certify that all information provide is correct and true, and that I am not a relative or engaged in any relationship with this client/student that would constitute a conflict of interest associated with my completion of this form.

Signature:

Date: