



SACRAMENTO STATE

California State University, Sacramento  
Services to Students with Disabilities

6000 J Street • Lassen Hall, Room 1008 • MS 6042 • Sacramento, CA 95819  
T (916) 278-6955 • F (916) 278-7825 • www.csus.edu/sswd

### Housing Accommodation Medical Provider Form

Instructions: Students requesting housing accommodations for North Village, a residential education community at CSUS should complete Section 1 and provide this form to their current qualified medical provider. The qualified medical provider should complete Section 2. The completed form should be submitted to [sswd@csus.edu](mailto:sswd@csus.edu).

The student named below may be eligible for services offered through Services to Students with Disabilities. To provide these services, we need information about the student’s functional limitations that affect living on-campus. Please be assured that the information provided below will be used in confidence for the educational benefit of the student. Services to Students with Disabilities reserves the right to make the final determination concerning the eligibility and continuation of services.

#### Section 1

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SAC STATE ID: \_\_\_\_\_

I authorize \_\_\_\_\_ (my medical provider and/or Medical Records Dept.) to release the requested health information and additional clarification relevant to the impact of my disability on my education.

\_\_\_\_\_

\_\_\_\_\_

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 associated with the need for a housing accommodation:

Diagnosis	Date of Diagnosis	Severity of Functional Limitation (circle one)			Permanent or Temporary	Date of Last Treatment
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		



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

3. For any diagnosis(es) where you indicated the functional limitation as "severe," please answer the following:

What is significant about the student's condition that severely impacts their functioning and how was the severity determined?

4. Please list any medications that you have prescribed:

MEDICATION/AUXILIARY AID	FREQUENCY	SIDE EFFECTS



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5. What major life activities are affected by the student's condition (e.g., seeing, lifting, walking, etc.)?

6. What type of housing accommodations are needed to provide the student equal access to the residential learning community?

7. Please describe the connection between the requested housing accommodation(s) and the major life activities affected by the student's condition(s):

8. Please list alternative housing accommodation recommendations should any of the requested accommodations not be available:



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## Information about Clinician / Medical Provider

Name

Specialty

Licensure Type

License Number

State issued

Expiration Date

By completing and signing this form, I certify that all information provided 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. Please return this form directly to [sswd@csus.edu](mailto:sswd@csus.edu).

Signature \_\_\_\_\_

Date \_\_\_\_\_