



The University seeks to provide students with disabilities reasonable accommodations in UA-owned housing in order to afford the student equal access to its housing. To consider a student's request for a reasonable accommodation in housing, Housing and Residential Communities requires documentation of the student's current disability from the treating and licensed clinical professional or health care provider thoroughly familiar with this student's condition and functional limitations and/or restrictions¹. Said professional or provider shall not be a family member through blood, marriage or other legal arrangement.

See housing.sa.ua.edu for **appropriate deadlines**. Once completed, please submit the form using either method below:

Fax: 205-348-7135
Attn: Alicia Browne

Mail: Alicia Browne
Housing and Residential Communities
Robert E. Witt Student Activity Center
Box 870399
Tuscaloosa, AL 35487

To be completed by requesting student

Student full, given name: _____

Student CWID: _____ Cell Phone: _____

Crimson Email: _____

I am (check all that apply):
 an incoming new student a returning student
 requesting cancellation requesting exemption

Requested Roommate *{Roommate requests may not be granted due to space limitations or accommodation}*:

Name: _____ CWID: _____

- I have read the Medical Requests portion of housing.sa.ua.edu.
- I understand that if I submit my Housing-Related Medical Accommodation Request Form after the deadline date my roommate preferences may not be considered.
- I understand that if I am interested in a room change during the contracted period, I will be limited to available rooms that can reasonably accommodate my disability.
- I understand that I must contact the Office of Disability Services to request any academic accommodations.
- I understand that specific building requests will not be considered.
- In evaluating my request, Housing and Residential Communities may need to consult the Student Health Center and the Office of Disability Services. As such, I authorize Housing and Residential Communities to discuss information about me, including any health information, medical condition or disability, to the Student Health Center and the Office of Disability Services.

Student Signature: _____ **Date:** _____
STUDENT'S NAME _____

¹ If a student's need for accommodation is apparent, Page 2 of this form is not required.



To be completed by requesting student's physician/clinician. This form must be completed in full and signed. If the spaces provided are not adequate, please feel free to respond to the questions on letterhead and submit with the remainder of the form completed.

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

1. Federal laws define a person with a disability as "any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

a) Does the student have an impairment that substantially limits any major life activities?
If yes, please describe the limitations and/or restrictions in detail.

b) How long has the student been under your care? When was the student/patient last seen by you?

c) How long is this impairment likely to continue?

2. Please indicate which of the following housing accommodations you suggest based upon the student's condition:

- | | |
|---|---|
| <input type="checkbox"/> Wheelchair-accessible room/building | <input type="checkbox"/> Vibration alarm |
| <input type="checkbox"/> Wheelchair-accessible shower/bath | <input type="checkbox"/> Storage space for medical supplies |
| <input type="checkbox"/> Kitchen access | <input type="checkbox"/> Landline phone |
| <input type="checkbox"/> Close proximity to restroom facilities | <input type="checkbox"/> Adaptive access technology |
| <input type="checkbox"/> Strobe alarm | <input type="checkbox"/> Other: |

3. Please describe why the suggested accommodations are necessary to enable the student to reside in UA-owned housing.

Other comments:

Signature of Provider: _____ **Date:** _____

License # and state and/or other pertinent credentials: _____

Print Name & Title: _____

Address: _____

Phone: _____ Fax: _____