CHAPMAN UNIVERSITY | **Student Affairs**
Residence Life and First Year Experience

DISABILITY ACCOMMODATION REQUEST FORM

STUDENT/PATIENT INFORMATION

Name

First Name: _____ Last Name: _____

Student Information

Student ID #: _____ Chapman Email Address: _____

Class Status: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

I am requesting accommodation for _____ semester/year.

Address

Street Address: _____

State: _____ Zip Code: _____ Country: _____

Contact Information

Contact Phone #: _____ Alt. Contact Phone #: _____

Note: All requests will need to be reviewed annually unless the disability is deemed unchanging in nature.

HOW TO COMPLETE THIS FORM

Please complete and submit this form and the REQUIRED letter[1] from your treating health care provider.[2] Letters from health care providers must be current[3] and address the needs you have for accommodation(s) in the on-campus housing environment. Keep in mind, the committee cannot infer the letter contents that are vague or lack detail and they will not interpret data submitted by providers.

Email the form and letter to: **housingDAR@chapman.edu**. Should you have any questions, please contact the Disability Accommodations Committee through this email.

[1] *Letter must be a typewritten letter from a licensed health care provider appearing on the professional letterhead stationery of the provider and dated. Notes on prescription pads and blank Word documents are not acceptable for the process.*

[2] *Health care provider must be a qualified licensed professional that specializes in the condition or disability and who is not a family member or personal friend of the requestor.*

[3] *Generally, current documentation is no more than 6 months old for psychological disabilities and no more than 12 months old for all other disabilities.*

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REQUIRED LETTER FROM A HEALTHCARE PROVIDER

To conduct a full review and evaluation of this request, the University requires a letter from your current licensed health care provider. The letter from your health care provider **must** include:

1. A detailed description of current functional limitations of the disability (a listing of the diagnosis is not required and will not substitute for the detailed description of functional limitations):
   - Functional limitation is not a diagnosis (ex., anxiety) or state of mind (ex., anxious). The term "anxious," as an example used in a functional limitation, is not helpful for a proper review of the request. Instead, speak to the behaviors, symptoms, or issues that occur due to the diagnosis in the college dorm environment.
2. A statement of whether the functional limitations are permanent or temporary and, if temporary, the expected duration.
3. Based on the information provided in Question 1, please provide a description of how the limitations support a need for a housing accommodation.
4. List *specific* suggested housing accommodations and any possible alternative accommodations.
5. Credentials of the diagnosing professional including contact and license information (if primary writer is unlicensed, provide co-signer or licensed supervisor signature)
6. A statement that the provider is not a family member or personal friend of the patient.

GUIDANCE FOR PROVIDERS

Disability-related accommodations are needed when a student cannot live in Chapman University housing without these alterations. Unfortunately, we cannot apply an accommodation to optimize the dorm environment or decrease the chance of an occurrence or outcome. Some examples where an accommodation cannot be applied:

- To provide an optimal study space in the room.
- To better manage or decrease symptoms due to a disability.
- To decrease stress and better organize life.
- As a remedy to roommate issues or concerns.
- To provide a private space for meditation, telehealth appointments, etc.
- To avoid or decrease the occurrence or potential occurrence of a negative event (i.e. roommate disagreements, stress, symptoms that may occur if...)
- A general description of a diagnosis is not helpful for our review. We require to know how this specific person's diagnosis presents itself through past exposure to similar events. We cannot reply to general textbook descriptions of a diagnosis.

DISABILITY ACCOMMODATION REQUEST FORM

AUTHORIZATION TO RECEIVE DISABILITY-RELATED MEDICAL INFORMATION

While the Residence Life and First Year Experience respects the private nature of medical records and the laws governing those records, for housing accommodation requests to receive every consideration, it is sometimes necessary to contact the health care provider. If this becomes necessary, we will use the release provided below, should you choose to sign the release. Please know that some health care providers have another preferred format for a release. If the health care provider does not accept the release below, you will be notified and it shall be your responsibility to contact the health care provider and arrange for a release.

If you do not provide a letter with all the points addressed and/or you do not authorize contact with the health care provider, there may not be sufficient information available for the University to conduct a review.

I authorize Chapman University Residence Life and First Year Experience Accommodations Committee to receive information from the licensed professional below. I authorize the licensed

Name of Licensed Professional:

First Name: Last Name:

Address of Licensed Professional:

Street Address:

State: Zip Code:

Contact Information of Licensed Professional:

Phone #:

Student/Patient Signature:

Name of Student/Patient (please print):

Signature of Student/Patient: Date: