Disability Support Services
www.stonybrook.edu/dss

Medical Documentation for Special Housing Request

Student’s Name:_________________________________ Student DOB:______________________________________

SBID#_________________________________ Telephone______________________________________

Stony Brook University complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services, and activities. Please complete the form below to assist D.S.S. in determining appropriate and reasonable disability accommodations. With regard to specific housing as a disability accommodation, there are a limited number of residence hall accommodations. We make our best effort to ensure that students with the most significant disabilities have priority placement so that they can actively participate in educational programs and activities. Additional documentation may be required.

To be completed by the student’s treating provider, NOT a family member. All items are required. Please print legibly.

Complete Diagnosis:__________________________________________________________

__________________________________________________________

Date of Diagnosis:__________________________________________________________

Date of last visit for this condition:_______________________________________

Procedures/assessments used to diagnose this student’s condition (ATTACH COPIES of assessment results used in making/confirming diagnosis):__________________________________________________________

__________________________________________________________

Severity of the condition: Mild Moderate Severe

Student is compliant with medical treatment for this condition: Rarely Sometimes Often Unknown

Does this student take prescription medication for this condition? Yes No If yes, which medications? Please note any side effects:__________________________________________________________

__________________________________________________________

Epi-Pen? Yes No

Has this student been treated in an emergency room for this condition within the last year? Yes No

Has this student received in-patient treatment for this condition within the last year? Yes No

Provider’s Signature:__________________________________________________________

Attach Business Card Here.

Describe how this condition substantially limits a major life activity ("basic activities that the average person in the general population can perform with little or no difficulty.")

__________________________________________________________

With what frequency does this student experience the above limitation(s)? Rarely Occasionally Frequently

How will the above limitation(s) interfere with this student’s ability to participate in student life (e.g., academics, recreation, etc.)?__________________________________________________________

__________________________________________________________

Describe any substantial equipment prescribed for this student’s home or school environment.__________________________________________________________

__________________________________________________________

Describe your follow-up plan with your patient for whom you have requested specialized campus residence housing:__________________________________________________________

__________________________________________________________

Recommended accommodation (must be clearly linked to functional limitations):__________________________________________________________

Physician’s Name:__________________________________________________________

Address:__________________________________________________________

License/Cert#:__________________State__________________

Specialty:___________________

Phone:____________________Fax:_________________