Dear Student,

The Office of Residential Programs offers a variety of living environments that accommodate many different lifestyle needs. Within this assortment of provisions, there are a limited number of medical single rooms available for students with severe medical, psychological, psychiatric, mobility, visual, or hearing impairment related conditions, whereby the symptoms of such conditions prohibit the student from living with a roommate.

Students who have such a condition may request an Accommodation of a Single Room evaluation with the Student Accessibility Support Center (SASC). Students must meet with an Accessibility Support Counselor at SASC and submit updated documentation (form enclosed) from their treatment provider in order to request an Accommodation of a Single Room.

**MEDICAL SINGLE ROOM PLACEMENT APPLICATION:**

A recommendation from SASC for the Accommodation of a Single Room is subject to renewal each semester. In order to be considered for this accommodation your condition must comply with the above requirement. You may be asked for updated medical and/or psychological/psychiatric documentation from your treatment provider.

Documentation must include all of the following:

1. Diagnosis of Condition
2. Nature of and severity of related symptoms
3. Length of time you have been symptomatic
4. **How your symptoms functionally prevent you from living with a roommate**
5. Medications
6. History of related hospitalizations, if applicable
7. A specific recommendation that it is your treatment provider’s professional opinion that an accommodation of a single room placement is essential for your health/mental health; even though this may increase isolation.
8. Verification from the treatment provider of ongoing treatment for your disability (dependent upon diagnosis)

The Accessibility Support Counselor will review your documentation to determine eligibility for a Single Room Accommodation. Please be sure to include your contact information on the documentation form so that SASC may contact you to discuss your request when it is reviewed for eligibility.

If you are eligible for a Single Room Accommodation, a recommendation will be made to the Associate Director of Residential Programs. The Associate Director of Residential Programs is not advised of your diagnosis. Information about the diagnosis and treatment of your condition remains confidential. It is entirely your choice to share or not share this information.
Medical Single_Documentation Form

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 SASC in determining appropriate and reasonable disability accommodations. Please know that additional documentation may be required.

To be completed by the student’s treating physician, NOT by 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): __________________________________________

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

Explain how symptoms functionally prohibit student from living with a roommate __________________________

Your specific recommendation that it is your professional opinion that an accommodation of a single room placement is essential for the student’s physical/mental health; even though this may increase isolation __________________________

Describe your follow-up plan for your patient: __________________________

Do you recommend academic accommodations? (must be clearly linked to functional limitations): __________________________

Nature of symptoms/ limitations __________________________________________

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

Provider’s Signature: __________________________________________

Affix Stamp or Business Card Here

Provider’s Name: __________________________________________

Address: __________________________________________

License/Cert#: __________________ State: ____________

Specialty: __________________________________________

Phone: __________________ Fax: __________________

Email: __________________________________________