Office of Disability Services

HOUSING ACCOMMODATION REQUEST FORM

21000 West Ten Mile Road C405
Southfield, MI 48075
Phone: 248.204.4100
Fax: 248.204.4115
Email: disability@ltu.edu

Lawrence Technological University (LTU) is deeply committed to the full participation of students with disabilities in all aspects of college life, including residential life. In accordance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA), LTU has established procedures to ensure that students with documented disabilities receive housing assignments that meet their needs as required by law.

The documentation below, along with the cover letter written by the student, will determine whether the student has a condition or combination of conditions that constitute a disability, and whether the disability causes limitations for which the student needs reasonable accommodation(s). Documentation will assist the Office of Disability Services in understanding how the disability impacts the student in the residence halls and the current impact of the condition(s) as it relates to the housing request. This form, and all relevant information, must be completed or provided by an appropriate qualified medical professional. All documentation and subsequent accommodations will be evaluated on a case-by-case basis.

NOTICE CONCERNING REDUCED DISTRACTION AND OR DISTRACTION FREE SPACES

Requests for a single bedroom as an accommodation based solely on a desire to have a “quiet, undisturbed place to study” or for a “reduced distraction environment” will not be granted. By virtue of the shared facilities, resources, and number of people living under one roof, it is not logical to assume that having a private room would provide for such a quiet, distraction-free space to any appreciable degree beyond living in a standard double room. Requests for a single bedroom as an accommodation requires documentation from a qualified medical professional that demonstrates a link between the request and disability.

FOR LTU OFFICE ONLY

Term/Year: □ Fall □ Spring □ Summer Year _____ Date Received: _____

Reviewed by: _____ Decision: _____

Notes: _____

_____

_____

TO BE COMPLETED BY THE STUDENT:

Name: _____ Banner ID: _____

Address: _____ LTU Email: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Gender: _____ Effective Term: ☐ Fall ☐ Spring ☐ Summer Year: _____

Requested Housing Accommodation: _____

_____

_____

Student Signature: _____ Date: _____

AUTHORIZATION OF INFORMATION

I authorize the provider listed below to release information related to my request to Lawrence Technological University's Office of Disability Services for the purpose of an accommodation to my housing assignment and to discuss this request with a staff member of LTU.

Name of Medical Provider: _____

Address: _____

City: _____ State: _____Zip: _____

Student Signature: _____

MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

A patient at your practice is a student at Lawrence Technological University and is requesting housing accommodations. Part of the process of requesting housing accommodations is submission of current medical documentation that provides insight into the student's condition, its impact on their ability to live on campus, and recommended accommodations. Please complete the following sections in full. If additional space is needed, please attach additional documentation.

Section I: Patient Information

Patient's Name: _____ DOB: _____

Diagnosis/Condition: _____

ICD-10 or DSM-V Code(s): _____

Date of diagnosis: _____

The condition is: ☐ Permanent ☐ Episodic ☐ Temporary

What is the severity of the condition? _____

When did you last see the student? _____

Is the student a current patient under your care? _____

List any prescription medications: _____

Section II: Definition of Disability

The Office of Disability Services provides reasonable accommodations to students with diagnosed disabilities. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, intellectual or developmental disabilities, emotional illness, drug addiction, and alcoholism. This definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use.

The term major life activities means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning and speaking.

Is the student disabled as defined above? ☐ Yes ☐ No

Does the student require medical/therapeutic equipment? ☐ Yes ☐ No

CONTINUED: MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Section III: Accommodation Recommendations

Does the patient's impairment(s) significantly limit any major life activities (see Section II) as would be encountered in a residential community? If yes, please describe in detail.

_____

_____

_____

What is the impact of the condition in the living environment? And the severity of that impact (mild/ moderate/ severe)? Please explain. _____

_____

_____

Considering the mental and physical requirement of being a student in college and life in the residence halls, what recommendations of accommodations or services do you recommend to address the functional impact you have specified for the student's medical condition? Please provide us with an indication of the level of need for the accommodation(s) (and the consequences of not receiving it). _____

_____

_____

Is the proposed accommodation a medical necessity for the student to live in residence halls, or believed to be beneficial? Please explain. _____

_____

_____

Please indicate whether and how the student may be at risk during an emergency:

_____

_____

_____

Additional information/comments: _____

_____

_____

CONTINUED: MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Healthcare Provider's Name: _____

Title: _____

Area of Specialty: _____

Type of License: _____

State of License: _____License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents above are true and accurate.

Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO:

The form can be turned in by mail, email or in person.

The Office of Disability Services, C405
Lawrence Technological University
21000 West Ten Mile Road
Southfield, MI 48075
Email: disability@ltu.edu