

Medical/Health Care Provider Fills Out and Signs Section Below:

STUDENT'S NAME: _____

Provider Completes the Section Below:

To determine eligibility for changes to the housing environment, the Penn State University requires current and comprehensive documentation of the student's condition from the a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). The provider completing this form cannot be a relative of the student. **Items 1 thru 5 must be completed in full.** If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

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

1) What is the student's medical condition/diagnosis? _____

a) How long has the student had this condition? _____

b) What is the severity of the condition? _____

c) How long is this condition likely to persist? _____

2) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

3) List this student's current medications(s), dosage, frequency, and adverse side effects.

a) Are there any significant limitations to the student's functioning directly related to the prescribed medications?

Yes _____ No _____

If yes, please describe. _____

4) Please state specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's medical (physical or emotional health) condition. Indicate why the change(s) to the housing environment you recommend are necessary (e.g., if you suggest a private bathroom state the reasons for this request related to the student's condition).

Please indicate whether any of the following are medically necessary:

- | | |
|---|--|
| <input type="checkbox"/> Proximity Reader | <input type="checkbox"/> Bench seat in shower |
| <input type="checkbox"/> Wheelchair-accessible building | <input type="checkbox"/> Bathroom safety bar |
| <input type="checkbox"/> Wheelchair-accessible shower | <input type="checkbox"/> Strobe alarm/doorbell |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Other: _____ |

5) If current treatments (e.g., medications) are successful, why are the above changes to the housing environment necessary?

The provider completing this form cannot be a relative of the student.

Signature of Provider: _____ Date: _____

License #: _____ State: _____

(Please print) Name/Title: _____

Address: _____

Phone: _____