Housing Accommodations Request Form

To be completed by student. Please print.

Name: ___________________________ Student ID: ___________________________

Campus Address: ___________________________

Semester and/or year to which this request applies:

(Accommodation requests must be made per academic year.)

Home Address: ___________________________

Home Phone: ___________________________ Home Email: ___________________________

Date of Birth: ___________________________

What is your class status? (Check one.)

☐ New ☐ Returning ☐ Transfer

Please list specific housing accommodation(s) and explain need based on documented disability.

Request(s)

Justification *

Signature: ___________________________ Date: ___________________________

Note – Applications are reviewed to ensure that the claimed disability meets the definition set by the Americans with Disabilities Act.
Permission for Release of Information

I give permission for the exchange of any medical, educational, sociological, or psychiatric information between the following Departments of the College of Charleston:

- Center for Disability Services
- Student Health Services
- Residence Life and Housing

To be completed by Student. (Please print)

Name of Diagnosing Professional:

Title of Diagnosing Professional:

Address:

Phone: Fax:

To be completed by student. (Please print)

Student's Full Name: Student ID:

Home Address:

Phone:

Email:

Signature: Date:

Return to: Center for Disability Services
College of Charleston
Office location: Lightsey Center, Suite 104
Mailing Address: 66 George Street
Charleston, South Carolina 29424
Voice: 843.953.1431
Fax: 843.953.7731
Email: SNAP@cofc.edu