COLLEGE of CHARLESTON

CENTER FOR DISABILITY SERVICES

Documentation of Disability-Related Need for Housing Accommodations

Please print.

To be completed by the diagnosing professional, who should not be a relative of the student.

Student's Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Date of Initial Contact with Student: _____ Date of last visit: _____

Is the condition: ____ permanent or ____ temporary – anticipated length: _____

Briefly describe the student's medical condition and physical limitations.

Diagnostic criteria / tests used:

Treatments/medications/devices or resources currently prescribed (name of medication and dose):

Expected duration, stability, or progression of the condition:

Is the student functionally impaired by one or more of the above listed conditions?

____ YES _____ NO If yes, specifically describe how the condition contributes to functional impairments or limitations to the student's housing needs.

What type of housing accommodation (s) does the student need?

Does the disability prevent the student from living with a roommate(s)? ____ Yes ____ No

If yes, please explain.

_____ _____

Signature and Credentials of Health Professional Date

Name and address of Health Professional (please type or print)

Phone: _____ Fax: _____

Please return to:

Center for Disability Services
104 Lightsey Center
College of Charleston
66 George Street
Charleston, SC 29424
(843) 953-1431
Or by fax: (843) 953-7731