FAYETTEVILLE STATE UNIVERSITY™

COUNSELING AND PERSONAL DEVELOPMENT CENTER

Student Name: ____________________________
Bronco ID: ________________________________

Housing Accommodation Request Form

To have your request for a housing accommodation considered, please submit a completed application by the indicated deadline (March 1st) AND complete the housing process as indicated through the Department of Residence Life and Housing.

Part 1: To be completed by student

Student Name: ____ **Date**: _____________

Bronco ID: ____________________ **Email Address**:________________@broncos.uncfsu.edu

Address: ____

Home Phone: ________________________________ **Cell Phone**: _____________________

Current Academic Level: ☐ Freshman ☐Sophomore ☐Junior ☐Senior ☐Graduate

Semester Requesting Accommodation: Fall ______ Spring _______ Summer_____

Do you have any Medical, Psychological, Physical or Disability Related Conditions that would affect your housing assignment? ☐ Yes ☐No *(If yes, check all that apply)*

Please indicate your diagnosis/diagnoses for which you are requesting a housing accommodation:

____
____
____

Counseling and Personal Development Center
Spaulding Building (next to Student Health Services)
(910)-672-1222
disabilityservices@uncfsu.edu

Adapted from Virginia State University's Housing Accommodation Request Form

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Student Name: ____________________________
Bronco ID: ________________________________

Please check the accommodation being requested for the term indicated.

☐ Single Room**	☐ Wheelchair access to elevator
☐ Private/Semi-private bathroom	☐ Wheelchair accessible furnishings
☐ ADA compliant bathroom (including roll in shower)	☐ Room with additional space for medical equipment
☐ First floor room access	☐ Visual doorbell (typically for students with hearing impairments)
☐ Wheelchair accessible dorm	☐ Proximity to building (specify)
☐ Other:	

****Single room accommodation is determined on a case-by-case basis and is limited by room space availability.**

Explain how the requested accommodation(s) relates to your medical diagnosis/diagnoses or disability.

____

____

____

What alternatives may work in lieu of the accommodations requested?
(If temporary, please provide expected duration)

____

____

____

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Student Name: ____________________________
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If you are specifically requesting a single room accommodation and that request is unable to be honored, would you be willing to be placed with a student needing a similar accommodation? ☐ Yes ☐ No

Is the accommodation for a temporary or permanent condition:
(If temporary, please provide expected duration)

____

____

Are you requesting academic accommodations for the same term? ☐Yes ☐ No
(If yes, please see the Counseling and Personal Development Center for intake forms)

Important Information Housing

Accommodation Form Deadlines:

March 1st

All requests will be prioritized in the order they are received.

Applications received after the stated deadline will be reviewed based on an availability basis. All housing requests are evaluated on a case-by-case basis.

Students will be notified by email to the address on file with the university.

Student Certification

I have provided accurate information to be used for housing accommodations at Fayetteville State University. I am aware it is my responsibility to meet all deadlines and submit any required documentation.

________________________________ ________________________________
Student Name (Print) **Date**

____
Student Name (Signature)

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Student Name: ___________________________
Bronco ID: _______________________________

Part 2: To be completed by Physician

Physician/Medical Provider Name: ____
Name of Practice: ____
Title: ____

Address: ____
City, State, Zip: ____
Phone: ________________________________ **Fax**: __________________________________
Email Address: ____

Diagnosis/Diagnoses of Medical Condition(s), Psychological Disorder or Primary Disability

List Diagnosis/Diagnoses:

____

____

Original date of diagnosis/diagnoses:

____

____

Date of most recent treatment or diagnosis/diagnoses:

____

____

List medication used for treatment for condition(s):

____

____

Prognosis for Diagnosis/Diagnoses:
______Permanent/Chronic _____6-12 Months ______6 months or less ______Episodic

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Student Name: ____________________________
Bronco ID: _________________________________

Severity of the condition:

_______ Mild _______Moderate _______Severe

Please provide detailed information concerning the nature and extent of the disability:

____
____
____
____
____
____

Provide specific information on the functional limitation as related to the academic environment:

____
____
____
____
____
____

Describe the current course of treatment including medication side effects:

____
____
____
____
____
____

Student Name: ______________________________
Bronco ID: ______________________________

Please provide the prognosis for the disability:

____
____
____
____

Please list any housing accommodations you recommend for the student and give justification for each recommendation *(be specific in sharing how the accommodation(s) or modification(s) is medically necessary/required for the student to have equal access to the residence hall; and, in the case of a single room request, describe how a shared space will adversely impact the student's ability to live in the residence hall).*

____
____
____

In the space provided, please address the following:
If accommodation is not provided, will there be a negative health impact for the student? What other alternative accommodations could satisfy as reasonable accommodations?

____
____
____

Please check which of the following major life activities is substantially limited by the disability:

☐ Seeing ☐ Eating ☐ Reading ☐ Walking
☐ Sleeping ☐ Learning ☐ Lifting ☐ Bending
☐ Thinking ☐ Hearing ☐ Speaking ☐ Concentration
☐ Standing ☐ Breathing ☐ Communicating ☐ Working
☐ Organizing Information ☐ Use of bodily functions
☐ Other(s): ____

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Student Name: ___________________________
Bronco ID: ________________________________

Signature below certifies records for this student are on file and the physician/provider will be available for clarification upon request.

_________________________________ _____________________________
Physician/Provider Signature **Date**

____
Physician/Provider Name

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