Disability Services Office

Application for Housing Accommodations & Services

The student must complete **Parts I & II** of this application. The student's healthcare provider must complete **Part III**, the Certificate of Disability. The completed application, along with all supporting documentation should be submitted to the Disability Services Office (DSO) for review by the Housing Accommodations Committee. All information is kept confidential under all applicable laws and is only shared with members of the Housing Committee for purposes of evaluation and determination of reasonable accommodations. In accordance with established policies and procedures, supporting documentation must be submitted to DSO in order to verify the functional limitations imposed by the disability. Documentation guidelines can be found in the DSO Handbook, located on our website at http://www.centenarycollege.edu/cms/en/academic-services/disabilities-services-office/ or by contacting the Disability Services Office at (908) 852-1400 ext. 2251. The Centenary Residence Life Department administers and coordinates the policies and procedures relating to accommodations within residence halls.

PART I. REQUEST FOR REASONABLE HOUSING ACCOMMODATIONS

Student Name: _____ Date: _____

Student ID #: _____ Phone: _____

Indicate class year **(please circle):** Freshman Sophomore Junior Senior

Transfer Graduate

Please specify your disability for which you are requesting a housing accommodation.

_____
_____
_____
_____
_____
_____
_____
_____

CENTENARY UNIVERSITY

Disability Services Office

Please indicate the type(s) of accommodation that you are requesting:

- ☐ Air conditioning unit
- ☐ Limited share bathroom
- ☐ Wheelchair accessible room
- ☐ Single room
- ☐ Flashing doorbell
- ☐ Flashing fire alarm
- ☐ Other (please list):

_____

_____

_____

Briefly describe why you are requesting the above accommodations:

_____

_____

_____

_____

_____

_____

_____

_____

Do you require evacuation assistance? **(please check)** ☐ **yes** ☐ **no**

If **yes**, please describe your need for assistance:_____

_____

_____

_____

_____

If "yes" is checked, your name will be forwarded to Leonard Kunz, Assistant Dean for Campus Safety. If you have any questions, please contact Dean Kunz at kunzl@centenaryuniversity.edu.

Disability Services Office

PART II. RELEASE OF INFORMATION

I, _____, give permission for the exchange of any medical, educational, psychosocial, or psychiatric information between the members of the Housing Accommodations Committee

AND the healthcare provider listed

Name: _____ Title: _____

Address: _____

Phone Number: _____ Email: _____

All information is kept confidential under all applicable laws and is only shared with members of the Housing Committee for purposes of evaluation and determination of reasonable accommodations.

_____ _____
Student Name (please print) I.D. Number

_____ _____
Student Signature Date

_____ _____
Staff Signature Date

Disability Services Office

PART III. CERTIFICATE OF DISABILITY

Student Name: _____Date: _____

Healthcare Provider Name: _____

Credentials and State License #:

_____

PLEASE RESPOND TO THE FOLLOWING QUESTIONS REGARDING THE ABOVE NAMED STUDENT:

1.) How long have you been treating the above named student?

_____

Date of the most recent evaluation: _____ Date of onset: _____

2.) Please provide the DSM V or ICD 10 codes for the condition(s) for which the housing accommodation is being requested:

_____
_____
_____
_____
_____
_____

3.) Please describe the symptoms the student is currently displaying:

_____
_____
_____
_____
_____

5.) What is the severity of the disorder/medical condition? (please check)

☐ Mild ☐ Moderate ☐ Severe

Comments:

_____
_____
_____

7.) Please list current medications and how the prescribed medications have affected the student's functioning?

_____
_____
_____
_____
_____

8.) What is the current treatment plan?

_____
_____
_____
_____
_____
_____

9.) Please list any current functional issues and/or the impact on activities of daily living within the residence halls that would require this accommodation.

_____
_____
_____
_____
_____

Attach Business Card Below

Healthcare Provider Signature: _____

Date: _____