INDIANA STATE UNIVERSITY

Housing Accommodation Provider Form

1. Student Requesting Accommodations

Name: _____ Student ID: _____

Contact Phone Number: _____ Date of Birth (MM/DD/YYYY): _____

2. Authorization of Release of Information (REQUIRED)

By signing below, I authorize Indiana State University Accessibility & Advocacy Resource Office to receive documentation and information, relevant to my request for a housing accommodation, from my provider who I have listed below. I also authorize my provider to discuss my condition(s) and the documentation and information provided with the appropriate Indiana State University personnel on an as-needed basis. This information is kept confidential. Typing name and date into the form constitutes an electronic signature.

Provider Name: _____ Provider Phone Number: _____

Provider Address: _____

Provider City: _____ Provider State: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian signature is only required if student is under 18 when the document is submitted

3. Information for Provider

The above-named student has requested a housing accommodations for a disability at Indiana State University. The Accessibility & Advocacy Resource Office is attempting to determine whether this student has a condition or combination of conditions that affects one or more aspects of the student's daily life beyond what a reasonable person without a disability would expect to experience during their lifetime. Current and comprehensive documentation will assist the Accessibility & Advocacy Resource Office in determining whether an accommodation is necessary to provide equal access to university housing.

To determine housing accommodation consideration, Indiana State University requires current and comprehensive documentation of the student's condition from a licensed clinical professional or healthcare 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.

Please attach any additional sheets, other information, evaluations, etc. which are relevant to the student's current condition and supports the student's request for a housing accommodation at Indiana State University.

4. Provider should completely respond to the following:

A. How long has the student been under your care, and when was the last time you saw the student?

What is the diagnosis and symptoms that impact the student's physical and/or cognitive function?

4. Provider should completely respond to the following: (continued)

Please describe the specific medical recommendations that affect the student's daily living conditions. How is this accommodation necessary for the student to have equal access to University housing?

Please explain how the accommodation is necessary for the student to use and have equal access to University housing as compared to a person without a disability.

Describe the current treatments, therapy plans, and any adaptive appliances or equipment used on a regular basis.

Please identify any other accommodation that may be equally effective in allowing the student to use and have equal access to University housing.

5. Provider Signature

Print Name: Title:

License or Certification: State:

Provider Signature: Date:

Date Received:	**Received by:**

Contact The Accessibility and Advocacy Resource Office with questions
at ISU-AARO@indstate.edu or call the office coordinator at 812-237-3829
AARO Fax Number: **812-237-4693**