Medical Housing Accommodation Request Form for Healthcare Professionals

This request form is to be completed by the treating healthcare professional of the Rutgers University-New Brunswick student requesting medical housing accommodations. Students may not complete this form on behalf of their treating healthcare professional. Treating healthcare professionals should answer all questions fully and include a signature and office stamp at the bottom of the form. Incomplete forms will not be accepted.

Any questions or concerns may be forwarded to:
Residence Life-Student Support
Davidson Hall D - Busch Campus
Rutgers, The State University of New Jersey
rlstudentsupport@echo.rutgers.edu
P.848-932-4371
F.732-932-1014

Student’s name: ______________________________________________________________________________

What is the student’s relevant medical diagnosis?: ____________________________________________________
________________________________________
____________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Date of diagnosis: ___________________ ___________________________________________________________

Date of last office visit: _________________________________________________________________________

The condition is (circle one):
- Permanent
- Temporary

If temporary, what is the anticipated duration? ______________________________________________________

Prescribed medications(s) (please indicate dosage):
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please describe the type, severity, and frequency of symptoms currently experienced by the student and how the condition interferes with one or more major life activities:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please describe the desired housing accommodations and explain how the request relates to the impact of the condition:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

How will the student manage these symptoms in other campus settings (i.e. classrooms, dining halls, libraries, etc.)?:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please indicate how this student may be a risk during an emergency evacuation (i.e. fire):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Healthcare Professional’s Contact Information

Name of Provider: ______________________________________________________________________________
License Number: ______________________________________________________________
Telephone Number: _____________________________________________________________________________

Please place treating healthcare professional’s stamped contact information in the space provided. If treating healthcare professional does not have a stamp, submitting letterhead will be accepted in its place. If left blank, form will not be accepted.

Signature: ___________________________________  Date: ________________________________

My signature verifies that I am the treating healthcare professional and that the contents of this form are accurate.

The healthcare provider completing this form cannot be a relative of the student.