RESIDENCE LIFE DISABILITY RELATED ACCOMMODATION REQUEST FORM
CLINICIAN FORM

DISABILITY DEFINITION:
Under Section 504 of the ADA, disability is defined as a physical or mental impairment that substantially limits one or more major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working. "Substantially limited" generally means that a person is unable to perform a major life activity that the average person in a general population can perform. The definition also considers any mitigating measures, such as medication, therapy, etc., that the person is engaging in that may relieve the substantial limitations caused by the impairment.

TYPE OF REQUEST

____ Single Room  ____ Placement on First Floor  ____ Physical Modification to Room  ____ Air Conditioner

____ Room Assignment Location  ____ Furniture/Equipment  ____ Other

RESIDENT DISABILITY RELATED INFORMATION

1. Does the resident have a disability under this definition? _____ Yes _____ No
2. DSM-5 Diagnosis: ____________________________
3. Date of Diagnosis: ____/____/____
4. What methods were used to evaluate the student? ______________________
5. Date of Last Evaluation: ____/____/____
6. Does the resident require ongoing treatment? ____Yes ____ No

7. What are the symptoms of this diagnosis/diagnoses, the magnitude, and the frequency?

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<th>Symptom</th>
<th>Magnitude</th>
<th>Frequency</th>
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8. Please describe how each diagnosed disability substantially limits the resident’s ability to perform a major life activity as compared to most people in the general population.

______________________________________________________________________________
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When completed, please fax to 715-425-0742 or send with the student. If you have questions, contact Alicia Reinke-Tuthill at 715-425-0740 or alicia.reinketuthill@uwrf.edu.
9. Please explain how the accommodation is necessary for the resident to use and enjoy University housing as compared to the general campus student population?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

10. Please describe what symptoms will be reduced by approving the requested resident housing accommodation?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

11. Please identify any other accommodation that may be equally effective in allowing the resident to use and enjoy University housing.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Clinician’s printed name ___________________________ Credentials ______

Professional license # ___________________________ Years in practice ___

Clinic/Agency name ___________________________ Phone ______

Address ___________________________

Clinician’s signature ___________________________ Date: ______________