<u>RELEASE OF INFORMATION</u>
FOR VERIFICATION HOUSING ACCOMMODATION

*Student will complete this page and provide it to their clinician. The clinician will complete the verification form.

STUDENT ACCESSIBILITY SERVICES
DOCUMENTATION FOR A HOUSING ACCOMMODATION

This form should be completed ONLY by the clinician.

Important : *Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.*

CLINICIAN NAME (PRINTED) ____

SIGNATURE OF CLINICIAN: ____

CREDENTIALS ______________________ SPECIALTY ____________________________

LICENSE/CERT. # ____________________________________ STATE ____________________

DATE: ______________________

My signature verifies that I am or have been this student's treating health care professional and that all the contents below are true and accurate.

Student Name : ____

1. Do you have a professional relationship with the patient/client involving the provision of health care or disability-related services? YES___ NO____

2. Confirmation of a disability (a physical or mental impairment that substantially limits one or more major life activities) : YES___ NO____

3. Specific housing accommodation needed by student :

____

____

____

4. Explain the relationship between the m p q L N _ p ¯ m L V m A I V] V p y A _ L p U N _ N N L
requested accommodation . *What is the specific disability-related barrier and how will this accommodation remove the barrier?*

5. Is there an alternative if the recommended housing accommodation is not available?
If so, please indicate.

6. Is there any other information you would like to provide regarding this student or the accommodation being requested?