Winona State University -- Housing & Residence Life

Health Care Form for Students Requesting Housing Accommodations

To evaluate how we can best meet your needs, we require specific information from both you and your examiner. You must complete the top portion of the form below. Also, to facilitate the process, we need you to fill out and sign the Authorization to Receive Health Care Information below. This gives us permission to speak with your examiner if we have questions relating to their recommendation for accommodation(s). Your health care provider must complete the rest of this form, sign it, and return the completed packet via PDF/JPG file to cguenther@winona.edu or mail a copy to:

Winona State University
Housing & Residence Life
Attn: Candice Guenther
230 Kryzsko Commons
175 W Mark St
Winona, MN 55987

This form is to request a housing accommodation based on a documented disability.
It is NOT a space to request a specific hall and/or room type preferences.

Student Fills Out This Section

Student Name: _____ StarID: _____

First Semester Enrolled at Winona State University: _____

Cell Phone #: _____

Personal Email Address: _____

Provide a summary of accommodation(s) being requested based on your disability:

_____
_____
_____
_____

Authorization to Receive Information:
I authorize Winona State University to receive information from the provider below:

Name of Provider: _____

Address (Street, City, State and zip): _____
_____

Student's Signature: _____ Date: _____

Medical/Health Care Provider Fills Out and Signs Section Below:

Student's Name: _____

Winona State University provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA: 1990). ***The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.**

To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing physician or health care provider (the provider completing this form cannot be a relative of the student). Items 1 through 6 must be completed in full. If space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

Please respond to the following items regarding the student named above:

What is the student's disability?

_____

_____

How long has the student had this condition? _____

What is the severity of the condition? _____

How long is this condition likely to last? _____

Describe the symptoms related to the student's condition that cause significant impairment in a major life activity.

_____

_____

_____

_____

List the student's current medication(s), dosage, frequency, and adverse side effects.

_____

_____

_____

_____

Are there significant limitations to the students functioning directly related to the prescribed medications? Yes No
If yes, please describe:

_____

_____

Does the student have a disability as a result of this condition? Yes No

If yes, please state specific recommendations regarding housing accommodations for this student, and a rationale as to why these housing accommodations are warranted based upon the student's functional limitations. Indicate why the housing accommodations you recommend are necessary (e.g. if you suggest a private room, state the reasons for this request related to the student's disability). This is NOT to support a student's hall and/or room type preference, rather the need for specific housing accommodations due to a disability.

_____

_____

_____

_____

_____

If current treatments (e.g. medications) are successful, why are the above housing accommodations necessary?

_____

_____

The provider may also send a report that provides additional related information.
The provider completing this form cannot be a relative of the student.

Signature of Provider: _____ Date: _____

License #: _____ State: _____

Name/Title: _____

Address: _____

Phone #: _____

It is imperative we receive verification of the provider's authenticity. All documentation must include an official clinic stamp on original letterhead.