

Medical Housing Application

TO BE COMPLETED BY STUDENT

Submit this completed application, *including supporting documentation from a physician, psychologist, or other health care provider* to either the Director of Health Services, the Director of Counseling and Psychological Services or, Educational Services Disability Specialist, depending on the nature of your application. The appropriate Director will meet with you to discuss your condition and then forward his/her recommendation to the Residence Life and Housing Office.

Student's Name (Please print or type): _____

Campus Address (hall and room): _____

Campus Mailbox: _____ Cell Phone: _____

Date of Birth: _____ Male: _____ Female: _____ Home Telephone: _____

Home Address (street, city, state, zip): _____

Is the basis for your application: Medical _____ Psychological _____ ADA Accommodations _____

Is there a record of your condition on file in the Health Services, Counseling and Psychological Services Office or, Educational Services Offices? Yes _____ No _____

Please describe your reasons for requesting medical housing by answering each of the following questions.

1. What is the medical/psychological concern and how severe is it?

2. Describe the measures including medication and dosages that are being employed to treat this condition.

3. What is the specific housing need and why is it important in treating this condition?

An approved Medical Housing application does not automatically guarantee a single room. Recommendations from the Directors of Health Services, Counseling and Psychological Services, or Educational Services will be sent to the Housing Office. The Housing Office will try to determine a suitable living space. Students with similar housing needs will be placed together whenever possible. All students must reapply each academic year for medical housing. There is an additional charge for single rooms.

Please indicate which school you are enrolled in:

College of Liberal Arts _____ Casperson School of Graduate Studies _____ Theological School _____

Please indicate the name, address and telephone number of your personal physician or psychologist who could be contacted if needed.

Name: _____ Telephone: _____

Address (street, city, state, zip) _____

I, (student's name) _____, verify that the information provided above is true and reflects my current medical or psychological situation. By signing below, I agree to allow information regarding my application to be shared with the Director of Housing, and others who are in a position to help me, including the Director of Health Services, Director of Counseling and Psychological Services, and the Dean of Student Life.

Student's Signature: _____ Date: _____

HEALTH SERVICES, COUNSELING AND PSYCHOLOGICAL SERVICES, EDUCATIONAL SERVICES USE ONLY

Date of appointment with applicant: _____ Remarks: _____

Recommendation: Approve* _____ Deny _____ Director's Initials _____

Note:

If application is approved, please send the Medical Housing Recommendation form to the Housing Office.