

# 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 Housing Office. **You also have to submit a separate housing application and a \$250 deposit to the 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 medical housing unit. 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.**

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.**