THE CATHOLIC UNIVERSITY OF AMERICA

Housing Accommodation Request
Clinician Care Provider Documentation Form

The Catholic University of America strongly believes in the benefits that on-campus living has to offer to our students in terms of academic success, personal development and involvement within the campus community. The Catholic University of America requires that all full-time, degree-seeking undergraduate students live in on-campus housing for the first six semesters of enrollment. The Office of Disability Support Services (DSS) supports students who may need a specific type of room, housing assignment, or other accommodation to mitigate: 1). any barriers presented by a communal, shared living environment or 2). any functional limitations to major life activities that may impact their full participation in an on-campus housing program.

The below student has submitted a Housing Accommodation Request to the Office of Disability Support Services (DSS). Supportive documentation from a qualified provider assists DSS in formulating a comprehensive understanding of a student's diagnosed disability or condition; what barriers or functional limitations may impact a student's experience; and what care and treatment is being offered. Submission of supportive documentation is part of an interactive process with the student, to determine whether reasonable accommodations are appropriate. Please complete this form in a timely manner and return it back to the student for submission directly to DSS.

When filling out the form below electronically, please use the Tab key to move from one line of the form to the next.

(Updated January 2023)

Student's First and Last Name:_____ **DOB:**_____

CUA Student ID Number:_____ **Student's CUA Email:**_____

TO BE COMPLETED BY THE TREATING CLINICIAN/PROVIDER -- PLEASE TYPE OR PRINT CLEARLY

Provider Name:_____ **Title:**_____

Signature:_____

Credentials:_____ **License #:**_____ **State:**_____

Professional Address:_____

City, State, Zip, Country:_____

Office Phone:_____ **Email Address:**_____

Date Completed:_____

Duration student has been under your care (Month/Year)? From:_____**To:**_____

Date student was last seen for an examination/appointment (Month/Year):_____

Office of Disability Support Services

620 Michigan Ave., N.E. | Washington, DC 20064 | 202-319-5211 | 202-319-5126 (FAX) |
cua-dss@cua.edu | dss.catholic.edu |

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Diagnosis: List your diagnosis of the student and the initial date of diagnosis (Month/Year) for any/each disability or condition.

_____

_____

_____

_____

How did you arrive at your diagnosis? Check all relevant items below that informed your diagnosis, adding any brief notes that you think might be helpful to aide DSS in a possible determination of reasonable accommodations for the student.

Behavioral Observations □ Developmental History □ Interviews with other Persons □

Medical History □ Medical Tests □ Un/Structured Interviews □

Other □ _____

_____

Provide detailed information regarding the student's diagnosis, including any present symptoms, any context regarding its duration or severity, as it specifically relates to the student being able to fully participate in a communal, shared living environment.

_____

_____

_____

_____

_____

_____

_____

Is the diagnosis chronic (Yes/No)?_____ If no, length of anticipated recovery:_____

Is the diagnosis progressive (Yes/No)?_____ If yes, describe the anticipated progression:_____

_____

_____

_____

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Within the chart below, indicate ways in which the student currently experiences functional limitations to particular major life activities as a result of their diagnosed disability or condition. Use the below rating scale to indicate the level of limitation (if applicable).

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	Major Life Activities	1	2	3	4	5	Major Life Activities
					Caring for self						Sitting
					Talking						Performing Manual Tasks
					Hearing						Eating
					Breathing						Working
					Seeing						Interacting with others
					Walking						Sleeping
					Standing						Other _____
					Lifting/Carrying						Other _____

Is the student currently taking medication(s) for this issue (Yes/No)?_____ If yes, what medication(s) is the student currently taking? For each medication, indicate any side effects (if applicable).

Medication	Side Effects

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Describe both current and relevant past treatment plans, and address their effectiveness.

_____

_____

_____

_____

_____

_____

What is the current recommended frequency of any ongoing or continued care?

☐ Once weekly ☐ Once monthly ☐ Every 3-4 months ☐ Every 6 months

☐ Once annually ☐ As needed Other: _____

Is there anything else that is important for DSS Staff to know about the student's disability or condition?

_____

_____

_____

_____

_____

_____

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