Office of Accessibility and Accommodations
Eastern Illinois University
600 Lincoln Ave
Charleston, IL 61920
217-581-6583

# PROVIDER HOUSING ACCOMMODATION VERIFICATION

**Student**: This form should be completed by a certified mental/medical health provider. This form will not be accepted if you have completed it yourself.

**Provider**: The following form can be completed to support the student's disability conditions by a relevant healthcare provider (psychologist, psychiatrist, therapist, licensed clinical social worker, medical doctor, optometrists, etc.) who is not a family member of the student and/or who does not have an inherent conflict of interest. Please include as much detail as possible regarding the student's disability, as this helps the Office of Accessibility & Accommodations to make informed decisions on accommodation requests. This information will be used in conjunction with the student's self-report to determine reasonable accommodation on an individual basis.

PLEASE NOTE: The purpose of the accommodation process is to ensure a student is not discriminated against on the basis of disability, and to ensure that the student has the same level of access to Eastern Illinois University as their non-disabled peers. The goal of an accommodation is equal access and opportunity, NOT to accommodate a specific preference or to ensure success at EIU. Housing accommodations related to a disability are not generally provided for any of the following reasons:

- To ensure the success of a student at EIU (we provide access, the student is responsible for success)
- To allow for a quiet place for studying (resources available on campus)
- To increase comfort or to alleviate discomfort in the housing arrangement (such as having a roommate-free experience to avoid addressing typical roommate conflicts)
- To serve as an alternative to the student developing the skills, abilities, and practices necessary to effectively live on campus
- Financial concerns (disability related or not)

Student's Full Name: _____

Date of Birth: ____/____/____ Date of Diagnosis: ____/____/____

Diagnosed disability or disabilities for which accommodations are being requested:

_____

DSM Code(s) (if applicable): _____

Does the disability limit one or more major life functions? ☐ Yes ☐ No

Is the student in treatment with you for the disability? ☐ Yes ☐ No

What is the projected duration of the disability? ☐ Permanent ☐ Temporary

First contact w/ student: ____/____/____ Most recent contact: ____/____/____

Does the request center on room adaptations necessary for safe and independent occupancy in the residence hall? ☐ Yes ☐ No

For each accommodation being recommended, please explain how the accommodation will mitigate the impact of the student's disability relative to the residential setting: _____

_____

_____

_____

_____

Is the request an integral component of a treatment plan? ☐ Yes ☐ No

Is there a negative health impact that may be permanent if the request is not approved? ☐ Yes ☐ No

What is the likely impact on daily life functioning if the request is not approved?

_____

_____

What is the likely impact on social development if the request is not met?

_____

_____

Are there possible alternatives you recommend if the requested configuration is not possible? _____

_____

Prognosis: Describe the anticipated progression or stability of the disability including any recommendations for future reevaluation:

_____

_____

Please complete this section only if the request pertains to allergens:

- What are the student's specific allergies? _____

_____

- What contact is needed for the allergen to trigger a reaction? _____

_____

- Is cross-contamination a significant risk? ☐ Yes ☐ No
- What measure or precautions must the student take in public or on a daily basis in their living environment to manage their allergies? _____

_____

Other comments/Notes:

_____

_____

_____

_____

**Certifying Professional Information:**

By my signature below, I certify that the information provided above is true and accurate. I confirm I have expertise, history, and knowledge of the student's impairment, which meets the standards of a disability as defined by the ADA, as amended.

Physician/Clinician Name: _____

Medical Specialty: _____

License/Certification #: _____

Address _____

Phone #: _____ Email: _____

Signature: _____ Date: ____/____/____

This information will be kept confidential and will not be included in the student's educational record. This document may not be released without written permission from the student, or in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA).

All information provided in this form will be considered but it is not the definitive information that informs our final decisions. Final determination will be decided by Eastern Illinois University in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments of 2008.

Office of Accessibility & Accommodations
(217)-581-6583 (Phone)
(217)-581-7208 (Fax)
accommodations@eiu.edu

NOTE: This form has been approved for use as of June 1, 2025. The institution reserves the right to update this form, as appropriate, at any time.