Please remember, documentation from your health care provider/physician managing this medical condition is REQUIRED. Please attach documentation or Health Care Provider Form before submitting.

Name: ___________________________ Date: __________

Year: (FY,So,Jr,Sr): _______ Phone: __________________________

Accommodation request: ____________________________________________

Please explain why you feel you need a single room (or other housing accommodation). Include a description of any attempts you have made to address your concerns with other adjustments/procedures.

____________________________________________________________________

____________________________________________________________________

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____________________________________________________________________

If you are currently living on campus with a roommate and need to request a medical single, please describe how your current housing situation is affecting your medical condition. Be specific:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

If the number of medical single applicants out numbers the singles available and your application is not approved, what are the best housing options our office may assist you with?

PLEASE READ CAREFULLY AND SIGN BELOW

Student’s signature represents that the above information is true and complete. Student hereby authorizes verification of above information and releases from all liability or responsibility all persons requesting and/or supplying such information.

Signature ___________________________ Date __________

Please remember documentation from your health care provider/physician managing this medical condition is REQUIRED. Please attach documentation or Health Care Provider Form before submitting.
Health Care Provider Form
(To be completed health care provider/physician)

Student: Please fill out the sections in this box before giving this form to your health care provider.

Name: __________________________ Year (FY, So, Jr, Sr): ______

Email: __________________________ Phone: __________________________

By signing, I authorized my physician and the Agnes Scott Health Center to share information about my condition.

Signature __________________________ Date ______________

This student has requested consideration for a single room based on a medical disability. Please describe the medical condition/diagnosis for which the student is requesting special housing accommodations and your recommendations regarding this disability accommodation. Also please add any other accommodations/supportive services this student will need?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you recommend the student take medication for this condition/diagnosis? Medication, dosage and frequency of use:

________________________________________________________________________

Do you recommend regular follow up for this condition? How often and by whom?

________________________________________________________________________

Will you be the primary health care provider dealing with this condition/diagnosis? Yes___ No___

If there are other providers involved please list name and phone numbers:

________________________________________________________________________

Do you recommend this student use supportive counseling services?

________________________________________________________________________

Please assist our office with prioritizing this student’s application. Recognizing Agnes Scott College has a limited number of singles and many students present a need, please rank the priority need of this student.

____ Urgent priority ___Priority ___Only if space available priority ___No opinion

Name: __________________________ Date: __________________________

Please print physician/health care provider name

Signature __________________________ Phone: __________________________

Signature of physician/provider