



VERIFICATION OF DISABILITY FOR HOUSING ACCOMMODATION

Student Accessibility Services provides accommodations to students with documented disabilities. To determine eligibility for housing accommodations, the university requires current and comprehensive documentation of disability from a qualified health professional currently treating the student.

Please Print Legibly

Student Name: _____

Date Completed: ____/____/____ Student's Date of Birth ____/____/____

1. Disability (DSM-5 or ICD-10): _____

2. Date of diagnosis: ____/____/____
First contact with student ____/____/____ Last contact with student: ____/____/____

3. What is the resulting impact to major life activities? Please check one:

Major Life Activity	None/Unknown	Mild	Moderate	Severe
Caring for oneself				
Performing manual tasks				
Seeing				
Hearing				
Eating				
Sleeping				
Walking/Standing				
Lifting/Carrying/Bending				
Working				
Speaking				
Breathing				
Concentrating				
Thinking				
Learning				
Other				
Other				
Other				

4. Please explain severity: _____



5. Is this diagnosis/condition considered temporary (<6 month duration)? _____

6. Are there any other factors that contribute to the student's need for the requested accommodation?

7. Please identify the measures (e.g. prescriptions, treatment, therapy, etc.) the student is using to mitigate the limitations caused by their disability. Explain how the mitigating measure(s) eliminates the substantial limitations.

8. What accommodations are reasonable and necessary to allow the student to participate in the living environment on campus?

9. Please explain how the housing accommodation is necessary for the student to use and access university housing as compared to a person without a disability?

10. Is there other information that you would like to share that would support this recommendation?

*Please attach additional appropriate documentation as desired.



Provider Information

**With student permission, Housing and Student Education - Assignment Coordinator may contact you for additional information regarding your recommendations.*

Signature: _____ Date: ____/____/____

Print Name and Title: _____

License or Certification #: _____

Office Address (street, city, state and zip code):

Office phone: (____)-____-_____

FAX Number: (____)-____-_____

Return to:

UW – Green Bay
Student Accessibility Services
2420 Nicolet Dr., SS 1700
Green Bay, WI 54311

920-465-2841
FAX: 920-465-2191
EMAIL: SAS@UWGB.EDU

It is recommended that all requests must be made at least eight weeks prior to the start of the semester.