LYCOMING COLLEGE
Residential Life Office
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Housing Accommodation Request
2024-2025

To Be Completed by Student

Name: _____ **Phone**: _____

Anticipated Graduation (month/year): _____

Request Type: ☐ Air Conditioner ☐ Private Room ☐ First Floor Room
☐ Other: _____

Request status: This request is ☐ New ☐ Previously Denied ☐ Previously Approved

Request time-frame: This request is for ☐ Fall 2024 ☐ Spring 2025

The request will be reviewed by a committee consisting of staff from Residential Life, Health Services, Counseling Services, and Disability Support Services who have my permission to release and discuss pertinent information concerning the above request. Further, I authorize members of this committee to discuss this request with my health care provider.

_____ _____
Student's Signature Date

To Be Completed by Provider

Provider's Name: _____ **License #:** _____

Address: _____

Telephone: _____ **Fax**: _____

The above-named student has indicated that you are the health care provider who has suggested a housing accommodation in the campus residence hall will be helpful in alleviating one or more of the identified symptoms or effects of the student's disability. So that we may better evaluate the request for this accommodation, please answer the following questions:

A. List all diagnoses that are pertinent to this request, along with the date and/or duration of the diagnosis. _____

_____

_____

*A person with a disability is defined as someone who has a physical or mental impairment that substantially limits one or more **major life activities**. Examples include, but are not limited to: walking, seeing, hearing, speaking, breathing, learning, working, and sleeping.*

B. Has the above condition(s) ever prevented the patient from completing a major life activity?
☐ No ☐ Yes If yes, which activities were impacted and how frequently?

_____

_____

_____

_____

C. In your opinion, is this accommodation medically necessary to afford the student an equal opportunity to use and enjoy College housing? ☐ No ☐ Yes Please explain.

_____

_____

_____

_____

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. By signing below, you approve the above statements.

_____ _____
Signature Date

This form will be accepted only if received directly from the health care provider.

Email: reslife@lycoming.edu

Fax: (570) 321- 4244

Mail: Office of Residential Life
Box 146
One College Place
Williamsport, PA 17701