

Verification Form: Reasonable Housing Accommodations

Rev. 03.11.2025

Directions: Please complete the Student Information portion of this form. Once this is completed, please give the ENTIRE form to your provider. Your provider should send this form directly back to the SAA office. It should not be returned to the student. The form should be mailed to Albright College, Office of Student Accessibility and Advocacy, PO Box 15234, Reading PA 19612 or faxed to 610-929-6793.

Student Information (must be completed by the student)

Student Name: _____ Date of Birth: _____

Biological Gender: Male Female Preferred Pronouns: _____

Are you currently using gender-inclusive housing? Yes No

Permanent Address: _____

Current Residence Hall and Room #: _____ Cell Phone: _____

(Please print legibly or type; illegible documents will not be processed)

SIGNATURE REQUIRED

I have read "Requesting Reasonable Housing Accommodations." I understand that if accommodations are approved they will be effective immediately or as soon as Residential Life can make the necessary adjustments. I understand that the following may occur based on the date of my approval, the needs being addressed by the accommodation, or the current availability of housing:

- My roommate or residence hall preference may not be considered.
- Albright may not be able to meet my accommodation(s) during the initial term of occupancy or during the semester in which the request is received, if it is received after the due dates.
- I may be relocated to a room that will meet my medical needs without my prospective or current roommate.
- If I have been reassigned housing due to a temporary medical need, I will return to my original housing once I have been medically cleared.
- If I am interested in a room change during the contract period, I will be limited to available rooms that can accommodate my needs.
- I understand that my request and documentation may be reviewed by the Student Accessibility and Advocacy (SAA) office and Albright College medical professionals and that my needs will be discussed with Residential Life.

Student's Signature: _____ Date Signed: _____

SIGNATURE OPTIONAL

I authorize Albright College to discuss my medical information and my request for a reasonable housing accommodation with the following person (e.g., parent, guardian) on my behalf:

Name: _____ Relationship to Student: _____

Address: _____

Phone Number: _____ Email: _____

Student's Signature: _____ Date Signed: _____

(Please **print legibly** or **type**; illegible documents will not be processed)

SIGNATURE REQUIRED

I authorize Albright College to receive information from the provider indicated below. I also authorize my provider to discuss my condition(s) via phone, email, or fax with the Albright College SAA office to clarify any questions relating to my condition(s).

Provider Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Student's Signature: _____ Date Signed: _____

Provider Section

Student's Name: _____ DOB: _____

To determine how Albright College can best meet the student's need for reasonable accommodations in college housing, the college requires specific diagnostic information from a licensed professional (e.g., medical doctor, neuropsychologist, psychologist, CRNP) who is familiar with the history and functional limitations of the student's physical or psychological conditions.

Please Note:

- The provider completing this form cannot be a relative of the student.
- Illegible or incomplete forms will not be processed.
- Please attach all relevant testing or evaluations to this report

History of Disability

Does this student have a disability as defined by the Americans with Disabilities Act as Amended (ADAAA)?

No Yes

If yes, please describe the disability requiring accommodation (include description(s) and DSM/ICD diagnosis(es):

(Please **print legibly** or **type**; illegible documents will not be processed)

History of Disability (cont'd)

Date of Diagnosis: _____

How long have you directly treated the student **for this condition**? _____

Frequency of contact with student **for this condition** (e.g., weekly, monthly): _____

Are you actively treating the student **for this condition**? No Yes

If yes, what is the date of the most recent visit with student **for this condition**: _____

What is the expected duration of the impairment?

- Short-term (less than six months)
- Episodic
- Long-term (six months to one year)
- Chronic (more than one year, with frequent recurrences)

Please explain why the above duration was chosen:

Is this student's condition expected to improve, worsen, or remain stable?

- Expected to improve
- Expected to worsen
- Expected to remain stable

Please explain:

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Functional Limitations and Recommended Accommodations

Please consider the student’s functional limitations within the college residence hall setting and describe what accommodations you recommend to address these limitations. Please complete one section for each recommended accommodation. Please be certain to connect the student’s symptoms to the recommended accommodation and explain how the accommodation will alleviate or address the symptoms.

Medical or psychological symptom/limitation: _____

How will this affect the student in the college housing environment? Please be specific.

Recommended reasonable accommodation:

How will this accommodation address/alleviate the symptom/limitation? Please be specific.

Medical or psychological symptom/limitation: _____

How will this affect the student in the college housing environment? Please be specific.

Recommended reasonable accommodation:

How will this accommodation address/alleviate the symptom/limitation? Please be specific.

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Functional Limitations and Recommended Accommodations (cont'd)

Medical or psychological symptom/limitation: _____

How will this affect the student in the college housing environment? Please be specific.

Recommended reasonable accommodation:

How will this accommodation address/alleviate the symptom/limitation? Please be specific.

Medical or psychological symptom/limitation: _____

How will this affect the student in the college housing environment? Please be specific.

Recommended reasonable accommodation:

How will this accommodation address/alleviate the symptom/limitation? Please be specific.

Is there any additional information that should be considered that is not reflected in this form or other attached documentation?

(Please print legibly or type; illegible documents will not be processed)

Provider's Certifying Information

Professionals rendering assessments/diagnoses and providing recommendations for reasonable accommodations must be relevant and qualified to do so (e.g., medical doctor, neurologist/neuropsychologist, psychologist, licensed counselor). The provider signing this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Signature: _____ Date: _____

Provider's Name: _____

Credentials: _____

License Number: _____ State of Licensor: _____

Office or Business Name: _____

Office or Business Address: _____

Office Phone: _____ Fax: _____

Email Address: _____

Thank you for taking the time to complete this form. We will contact you for clarification if necessary.

Directions for Submitting This Form and Supporting Documentation:

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

Albright College
Office of Student Accessibility and Advocacy
1621 North 13th Street
Reading PA 19604