UT MARTIN

Office of Disability Services

DISABILITY-RELATED HOUSING ACCOMMODATION REQUEST

The University of Tennessee at Martin Office of Housing refers, or forwards, all medical or disability-related requests for housing accommodations to the Office of Disability Services. The information is kept confidential and is only used to evaluate accommodation requests. Each student's situation is considered individually and carefully. In order to gauge how we can best meet your needs, the Office of Disability Services requires specific information from both you and your healthcare professional.

Name: ____ Date of Birth: _________________________

MEDICAL/MENTAL HEALTH PROFESSIONAL DOCUMENTATION

This section is to be completed by the student's physical or mental health care provider.

History of presenting problem and current medical condition/diagnosis:

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Expected duration of the condition:

___Temporary ___Permanent ___Stable ___Progressive

Describe the symptoms related to the medical condition that cause significant impairment to a major life activity (i.e., walking, breathing, sleeping, seeing, hearing, learning, and socializing). Please relate it to accommodations requested.

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

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Please indicate below your recommendations regarding housing accommodations for this student. Please note that the accommodations marked with an asterisk (*) are extremely limited and will only be considered for students meeting ADA criteria. Housing accommodations are based upon the student's functional limitations and level of need.

____Automatic Door Opener
____Close to bathroom
____Kitchen access in housing*
____No extended housing (not tripled)
____Semi-private bath
____Single room*
____Strobe light emergency
____Wheelchair accessible
____Other:______________________________

Further explanation for any of the above:______________________________

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Please attach any additional documentation that might be helpful in the accommodation process. (e.g., medical file notes, test results, etc.)

Name of Professional (Print):______________________________

Signature of Professional:______________________________Date:______________

License #:______________________________State:______________

Address:______________________________

____

City:______________State:______________Zip:______________

Phone:______________Email:______________________________

PLEASE EMAIL, MAIL, OR FAX INFORMATION TO:

OFFICE OF DISABILITY SERVICES

206-209 Clement Hall
DisabilityServices@utm.edu
731.881.7195
Fax: 731.881.7702

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