RUTGERS
Student Affairs

Residence Life-Student Support
Davidson Hall D-Busch Campus
Rutgers, The State University of New Jersey
90 Davidson Road
Piscataway, New Jersey 08854

http://ruoncampus.rutgers.edu/support
rlstudentsupport@echo.rutgers.edu

p. 848-932-4371
f. 732-932-1014

Medical Housing Accommodation Request Form for Healthcare Professionals

This request form is to be completed by the treating healthcare professional of the Rutgers University-New Brunswick student requesting medical housing accommodations. Students may **not** complete this form on behalf of their treating healthcare professional. Treating healthcare professionals should answer all questions fully and include a signature and office stamp at the bottom of the form. **Incomplete forms will not be accepted**.

Any questions or concerns may be forwarded to:

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rlstudentsupport@echo.rutgers.edu
P.848-932-4371
F.732-932-1014

Student's name: _____

What is the student's relevant medical diagnosis?: _____

_____

_____

_____

Date of diagnosis: _____

Date of last office visit: _____

The condition is (**circle one**):

- Permanent
- Temporary

If temporary, what is the anticipated duration? _____

Prescribed medications(s) (please indicate dosage):

_____

_____

_____

Please describe the type, severity, and frequency of symptoms currently experienced by the student and how the condition interferes with one or more major life activities:

_____

_____

_____

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Please describe the desired housing accommodations and explain how the request relates to the impact of the condition:

_____

_____

_____

How will the student manage these symptoms in other campus settings (i.e. classrooms, dining halls, libraries, etc.)?:

_____

_____

_____

Please indicate how this student may be a risk during an emergency evacuation (i.e. fire):

_____

_____

_____

Healthcare Professional's Contact Information

Name of Provider: _____

License Number: _____

Telephone Number: _____

Please place treating healthcare professional's stamped contact information in the space provided. If treating healthcare professional does not have a stamp, submitting letterhead will be accepted in its place. **If left blank, form will not be accepted.**

Signature: _____ Date: _____

My signature verifies that I am the treating healthcare professional and that the contents of this form are accurate.
The healthcare provider completing this form cannot be a relative of the student