



Housing and Meal Plan Accommodations  
Certification of Medical Condition / Disability Form  
PART 3 of 3

**To Be Completed by Diagnosing/Treating Professional**

1. Fill out information below.
2. Provide information addressing the nine separate items listed below **on your letterhead**. Incomplete documentation will not be considered.
3. Should the information requested below be contained in a current, comprehensive evaluation report, attach a copy of the report to this form.
4. Please note: The patient should NOT be an immediate family member, friend or business associate of the provider. Documentation for an emotional support animal must be provided by a licensed mental health practitioner.
5. Fax completed report to 843-349-5042

**Student Information:**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Qualified Diagnostic/Treating Professional Information:**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Certifications or Licensure: \_\_\_\_\_

**Check The Most Appropriate Description For This Individual:**

*I, the undersigned diagnostic/treating professional, certify that the above named student:*

**Check One:**

- Meets the definition of a **disability\*** as defined by the American's with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and the Fair Housing Act.  
*\*Impairment that substantially limits a major life activity.*
- Has a medical condition that is not a disability, but may warrant consideration for special housing modifications.
- Does not have a condition that would require modification(s).

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provide the following information on letterhead:

1. Diagnostic statement identifying the condition or disability.
2. Date of the most current contact and date of the original diagnosis.
3. Description of the diagnostic tests, methods and/or criteria used to diagnose the condition or disability.
4. Description of the current symptoms and the **substantial functional impact of the condition or disability on a major life activity** (specifically housing or meal plan accommodations).
5. Treatments, medications, and/or assistive devices/services currently prescribed or in use.
6. Description of the expected progression or stability of the impact of the condition or disability over time, particularly the next 5 years.
7. Whether the condition or disability described is permanent/chronic, long term (6-12 months), or short-term/temporary (6 months or less).
8. List specific housing or dietary requirements needed to accommodate the student's condition (Examples: living space with no carpets, low sodium diet). **DO NOT RECOMMEND EXEMPTION FROM THE HOUSING OR MEAL PLAN.** Only university staff has sufficient knowledge of on-campus options to determine if a student's needs cannot be accommodated.
9. Explain how the accommodations recommended are necessary for the student to use and enjoy University housing as compared to a person without a disability.