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 your name, certification and contact information below.
2. Provide information addressing the nine separate items listed below by filling out this form legibly. Incomplete forms will not be considered.
3. Should the information requested below be contained in a current, comprehensive evaluation report – please attach a copy of the report to this form.
4. Please note: The patient should NOT be an immediate family member.
5. Fax completed report to 843-349-5042; Attn: Wendy Woodsby

Qualified Diagnostic/Treating Professional Information:

Please type or print. Thank you.

Name: _____
Title: _____
Certifications or Licensure: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____Fax Number: _____
Email: _____

Student Name: _____
Student ID#: _____ Date of Birth: _____ Sex: ☐ M ☐ F
Address: _____
City, State, Zip: _____
Home Phone: (_____) _____ - _____

Please 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.
**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).

Please provide comprehensive answers to the following questions.

Student Name: _____ (physician's page 2)

1. Diagnostic statement identifying the condition or disability:

2. Date of the most current contact: _____

3. Date of the original diagnosis: _____

4. Description of the diagnostic tests, methods and/or criteria used to diagnose the condition or disability:

5. 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):

6. Treatments, medications, and/or assistive devices/services currently prescribed or in use:

7. Description of the expected progression or stability of the impact of the condition or disability over time, particularly the next 5 years.

8. The condition or disability described above is:

- ☐ Permanent/Chronic
- ☐ Long term: 6-12 months
- ☐ Short-term/Temporary: 6 months or less

  Expected duration: _____

9. Please 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.

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Signature of Diagnosing / Treating Professional Date