

Request for Accommodations

Hope College Accommodations Review Committee • Student Development
141 East 12th Street • Holland, MI 49423 • Telephone: 616-395-7945

Due to the specific nature of a request for accommodations, alternate forms or letters may not be accepted and will delay process.

Part I: To be completed by the Student:

I, _____, hereby authorize the exchange and release of the following confidential information to the Accommodation Review Team. This team may consist of professional representatives from the Hope College Health Center, Counseling and Psychological Services, Residential Life, Disability Services, and Dean of Students. The purpose of this disclosure is to determine my eligibility for accommodations based on medical or psychological conditions.

I give consent for the Accommodations Review Committee to contact my treating professional for additional information as needed. Any such discussion will focus on the condition described on this form only.

I understand that my request for housing accommodations cannot be addressed until all required documentation is received by the Accommodations Review Committee. I also understand that I will be charged the established room rate for the hall and type of room where I am assigned.

Date: _____ **Signature:** _____

Student Information:

Last Name: _____	First Name: _____	M.I: _____
Student ID#: _____	Phone #: _____	DOB: _____
Address: _____		
City: _____	State: _____	Zip: _____

Semester Request Accommodations to Begin:

___ Immediately (*Student currently living in housing*) ___ Incoming 1st year student

___ Transfer student ___ Returning student (year ___)

Please indicate the housing accommodations you are requesting:

- | | |
|--|--|
| ___ Wheelchair Accessible Room | ___ Single Room |
| ___ Modified equipment for deaf or hard of hearing persons | ___ Private Restroom |
| ___ Modified equipment for the visually impaired | ___ Lower/1 st floor assignment |
| ___ Service animals (Therapy pets are not allowed on campus) <i>*additional forms required</i> | |
| ___ Other (Please specify: _____) | |

Explain how the accommodations you are requesting will impact your current symptoms: _____

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Medical/Mental Health History

Information reviewed by the Hope College Assistant Dean for Health and Counseling and will result in a recommendation given to the Accommodations Review Committee.

Part II: To be completed by your licensed physician/professional:

Relevant Diagnosis (disability, acute or chronic medical or psychological condition): _____

Primary symptoms/behavior addressed in treatment, including date of onset: _____

Brief History of Presenting Problem: _____

Past Treatment: _____

Current Treatment, including specific medication(s), and compliance: _____

Description of any current functional limitations: _____

Accommodation Request: *(Please indicate if this is acute or chronic)* _____

Recommended Treatment Plan:

Continued treatment not necessary at this time. *Please explain the request for accommodation without further treatment.* _____

Patient will remain in treatment with current provider(s). *Please list the date of the next scheduled appointment.*

Treatment should be transitioned to Hope College or local provider(s).

Additional Recommendations or Information: _____

Licensed Physician/Professional providing this report (Please print):

Name: _____		
Credentials: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone #: _____	Fax#: _____	
License# and State of license: _____		

Signature of Licensed Physician/Professional

Date

Return this completed Request for Accommodations Form to:

**Hope College Accommodations Review Committee
Student Development
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Holland, MI 49423**