



St. Catherine University
Residence Life Office
2004 Randolph Avenue
Mail #4264
St. Paul, MN 55105

Verification of Medical Accommodation

Students requesting support services under laws pertaining to nondiscrimination for individuals with disabilities such as the Americans with Disabilities Act (ADA) and section 504 of the Rehabilitation Act of 1973, are required to submit documentation to verify their eligibility for services and accommodations. This documentation must indicate evidence that the disability substantially limits a major life activity such as learning. The provision of “all reasonable accommodations” is based on the current impact of the disability on academic performance. Thorough documentation is needed to help determine the reasonable and appropriate accommodations that the student is qualified to receive. Therefore, it is in the student’s best interest to provide recent and appropriate documentation.

The office of Residence Life at the St. Catherine University strives to ensure that qualified students are accommodated. The mandate to provide reasonable accommodation does not extend to adjustments in housing rates for rooms occupied below recommended occupancy (i.e. double as a single)

The student named below is requesting an accommodation due to their medical disability. So as to ensure that this accommodation request be considered, the Residence Life Department requires that the following form be completed by a qualified professional who has first-hand knowledge of the student’s condition and is an impartial individual not related to the student. It must be printed on official clinic letterhead or a cover letter from the attending physician must be attached.

Last Name _____ First _____ ID# _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth ____/____/____ Phone _____ e-mail _____

If you have any questions regarding the nature of this information needed for students with medical needs, please call the Department of Residence Life at 651-690-6617, Monday through Friday from 9:30 AM to 4:30 PM. This form should be returned to the St. Catherine University, Residence Life Office, 2004 Randolph Avenue, Mailbox #4264, St. Paul, MN 55105.

Thank you for your assistance in completing this form.

Professional Information (this section is to be completed by a qualified professional)

Have this report completed on office letterhead by attending physician.

Date of Completion of Form ____/____/____

Name Certifying Professional _____ (M.D.)

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Professional Title _____

License/Certification Number and Issuing State _____

Date of Initial Contact with Student ____/____/____

Medical Condition Diagnosis: _____

Date of Diagnosis: ____/____/____

Describe symptoms associated with this medical condition _____

Date of Last Contact with Student ____/____/____

Medications

Current medication including dosage and side effects

Long-term medication plan

Current compliance with medication plan

Prognosis for medication plan (Include likelihood of improvement or deterioration and within what approximate timeframe)

Therapeutic Interventions

Planned therapeutic interventions

Current compliance with therapeutic interventions

Does this person currently pose a threat to herself or others? If so, please specify.

History of hospitalization

Impact of Condition on Residential Success

Please identify the specific residential abilities or functions that are compromised by the disorder. Indicate severity of these limitations

Please specify the impact of the disorder and prescribed medications upon living environment and residential activities.

Suggested Accommodations

Note: Final determination of appropriate accommodations will be determined by our office in accordance with mandates of the Rehabilitation Act of 1973 and the Americans with Disability Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation must be accompanied by explanation of its relevance to the diagnosed disability.

We would appreciate that you indicate the style of housing the student can handle based on their current medical condition and not the *desires* of the student. For instance if a student in their current medical situation could live with a roommate but may need to discuss the situation with that roommate, please indicate shared dwelling. If the shared dwelling is suitable, but a single would be preferable, please indicate why in the notes below.

Type of Housing **needed** (circle):

1. Single
2. Shared dwellings (double, triple, quad)
3. Apartment
4. Wheel Chair Accessible Room

Why is this particular style of housing needed?

Special Services Required:

1. Access to sink
2. Access to a tub
3. Access to a kitchen
4. Private bathroom
5. Private kitchen
6. Other

Why are these particular services required?