



## HOUSING ACCOMMODATION REQUEST FORM

**Student:** Please complete the demographic information below and then have the health care provider who treats you for your medical or psychological condition complete Part II of the form. (Family members are not acceptable medical providers.) In order to fully evaluate your request, the documentation will be reviewed by the Special Accommodations Evaluation Committee which considers student requests for all special housing accommodations and determines appropriate assignments. The committee is composed of professionals from the Academic Resource Center (Samuel Rudin ARC), the College Assistance Program (CAP), the Health Center, the Counseling Center and Residential Life. Information submitted for the committee's review will be protected as a confidential file in the Office of Residential Life.

**Health Care Provider:** Special housing is extremely limited. **Only those students with the greatest medical and psychological need(s) will be recommended and granted special housing arrangements.** In order to make this determination, it is important that medical and/or psychological documentation support the request and that all of the questions below are answered completely.

*Please Print*

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### Part I: To be filled out by the student

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

Semester/Year: \_\_\_\_\_ Birth date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_@iona.edu

Check one of the following: \_\_\_ Freshmen \_\_\_ Transfer \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior

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### Part II: To be filled out by the healthcare provider.

1. What is the physical or mental impairment; include current problems and severity.

2. List any test/evaluation measures used with the dates and results of the tests/evaluation. Please attach clinical data documenting the medical or psychological problem and the nature of the impairment.

3. What is the specific housing need and why is it important to this problem?

4. What are possible alternatives to the requested accommodation?

Provider's Signature and Credentials: \_\_\_\_\_

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

Provider's Name, Printed:

\_\_\_\_\_

Provider's Address:

\_\_\_\_\_

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By signing this document, I authorize Iona College to contact me to obtain further patient information if needed. I further certify that the above information is valid and truthful to the best of my knowledge.

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**Please return form to:** FAX to: 914-637-7775

Mail to:                   Attn: Special Accommodations Evaluation Committee  
Residential Life Office – Iona College  
715 North Avenue  
New Rochelle, NY 10801

This completed form must be received by July 1 in order to be considered.