



ACCESSIBILITY AND DISABILITY SERVICES
8000 YORK ROAD
TOWSON, MD 21252
T. 410-704-2638
F. 410-704-4247
www.towson.edu/ads

REQUEST FOR HOUSING ACCOMMODATIONS VERIFICATION FORM

Towson University provides housing accommodations on a case-by-case basis for students with a documented disability in accordance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. The Office of Accessibility & Disability Services and Housing & Residence Life work closely together to identify appropriate and available housing solutions for students who qualify for an accommodation(s). Students must complete and submit this form in order to receive consideration. **Please note a diagnosis alone does not necessarily qualify you for the requested accommodation(s). The documentation must also support the need for the accommodation.**

Returning students: Returning students should submit their requests well in advance of room selection for the following academic year with a priority deadline of **February 28th**. Please be aware that as space becomes more limited, requested accommodations may not be available.

New students: The priority deadline for incoming freshmen and transfer students is **June 15th**. Please be aware that as space becomes more limited, requested accommodations may not be available.

If the need for the accommodation arises at another time during the academic year, when a student already resides in University housing, they should contact ADS as soon as practically possible. Please note TU cannot guarantee that it will be able to meet the accommodation needs during the term in which the request is received.

Please carefully review the [Information for Requesting Reasonable Housing Accommodations](#) **before completing the Request for Housing Accommodations Verification Form.



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SECTION I: To be completed by the student

1. Student Name _____ TU ID _____ Today's date _____

Classification:

- ___ Incoming Freshman
___ Transfer
___ Returning Student
___ Other

2. Please specify the semester and year for which you are requesting an accommodation:

_____ Semester _____ Year

3. Name of the disability for which accommodations are being requested:

Three horizontal lines for text entry.

4. Please describe your symptoms and probable impact on living in campus housing:

Three horizontal lines for text entry.

5. Please state your housing accommodation request(s):

Three horizontal lines for text entry.

The information I have provided is accurate to the best of my knowledge. I authorize and consent for ADS to consult, as needed, with medical professionals to clarify documentation and University personnel on a need to know basis.

Student Signature: _____ Date: _____



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SECTION II: To be completed by a qualified medical professional

(Please note a qualified medical professional is a licensed healthcare provider within the field of specialty. For example, mental health disabilities must be documented by a licensed mental health professional.)

**For examples of common housing accommodation requests, please refer to the Information for Requesting Reasonable Housing Accommodations.

1. Name of the disability or medical condition for which accommodations are being requested:

Date of Diagnosis: _____

2. Does the condition significantly impact a major life activity? ____ YES ____ NO
Please explain. _____

3. Please list the symptoms and frequency of symptoms the student is experiencing that are causing impact on one or more major life activities.

4. Describe the severity of the condition and its probable impact on the student's living situation at TU.

5. Please describe the requested housing accommodation(s) and how each request specifically correlates with the student's disability or medical condition.

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SECTION II: Continued

6. Please provide any further information you believe would be helpful.

SIGNATURE OF CERTIFYING MEDICAL PROFESSIONAL

To determine eligibility for a housing accommodation, Towson University requires the student to be a qualified student with a disability (i.e., have a physical or mental impairment that substantially limits one or more major life activities) and submit documentation from an appropriate licensed healthcare provider. As the provider you must be familiar with the history and functional limitations of the student's disability. You are not eligible to complete this form if you are related to the student or a close friend.

I verify that this form has been completed by me or a designated staff member, that I am treating this student, and that I am not a relative or close friend of the student.

Printed Name/Credentials/Field _____

Signature _____ Date _____

License number _____

Address _____

Phone _____ Fax _____