STOCKTON UNIVERSITY | WELLNESS CENTER

Learning Access Program
Housing Accommodation Request

Section I: Student Information

Please complete the following information.

Student Name_____ Z# _____

Date of Birth _____/_____/_____ Cell Phone _____

Are you registered with the Learning Access Program? ☐ Yes ☐ No*

*If no, you must register with the Learning Access Program and have the Documentation of Diagnosed Disability form completed by your provider prior to applying for housing accommodations. Please call 609.652.4988 to schedule an intake appointment.

Current Housing Situation:

_____

_____

Accommodation Request:

_____

_____

Time Requesting Accommodations:
Please note the terms in which you will need the accommodation. Housing accommodations requests must be submitted each academic year.

◯ Fall ◯ Spring ◯ Summer Academic Year: _____

Please provide a personal statement describing your condition and your need for each of the accommodations that your are requesting.

_____

_____

_____

_____

Section II: Provider Information

Student Name_____ Z# _____

The above named student has indicated that you are the physician, psychiatrist, social worker, or mental health provider who has conducted and/or supervised their diagnostic assessment. So that we may better evaluate the request for residential accommodations, please answer the questions below:

1. **Diagnosis:** (please list all relevant diagnoses and co-existing conditions according to DSM 5 and/or ICD-10)

_____

Date of your last clinical contact with student: _____/_____/_____

2. **Functional Impact** (please provide details of limitations and how they relate to living in University housing):

_____

_____

3. **Suggested Accommodations** (please list specific housing accommodations you suggest based on your assessment of the student's clinical history and diagnosis):

_____

_____

If this accommodation could not be provided, what would be the impact on the student?

_____

_____

4. **Additional Information** (Optional):
Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and additional recommendations that may assist in determining appropriate accommodations and interventions.

_____

_____

Thank you for taking the time to complete this form. If we need additional information we may contact you at a later date. The physician, psychiatrist, social worker, or mental health provider that completed this form must sign and date below and provide either the provider stamp or a copy of business card. Please return the completed document via fax to 609.626.5550 or by email to lap@stockton.edu

Signature: _____

License # _____

Date: _____/_____/_____

Provider Stamp or Business Card Required