St. Bonaventure University is a residential campus; therefore every effort will be made to accommodate housing and dietary needs on campus for students with medical and/or psychological disabilities. Current documentation from a licensed and qualified professional is required in order to determine appropriate accommodations based on functional limitations that will impact the student in a residential setting. The Housing Documentation form must accompany this form and may be picked up in the Office of Residential Education and Housing, Reilly Center 206.

- All parts of the Request for Housing Accommodations must be completed as thoroughly as possible. Requests are kept in a confidential file and will only be shared as appropriate with Health Services, the Office of Disability Support Services, and the Office of Housing & Residential Education.
- As per University policy, all undergraduates who live in a traditional residence hall are required to have a meal plan.
- Housing assignments are approved annually. Even if your current housing reflects consideration of your health/disability-related needs, you must apply for your housing accommodation using this process each academic year. Previous circumstances do not automatically ensure similar housing arrangements in the future.
- The request authorizes us to contact your clinician if your documentation is insufficient or needs clarification. Your signature below signifies your understanding of the process and your obligations.

Student Signature: _____________________________________________ Date: ____________________

Please return the completed form and supplemental documentation to:
Housing & Residential Education
St. Bonaventure University
PO Box BZ
St. Bonaventure, NY 14778
Fax: 716-375-2647

Revised 5/23/2012
Request for Housing Accommodations:
Section B (must be submitted by student with section A)

Please print legibly

Name: ___________________________   ID#: ____________

Mailing Address: _______________________________________________________

Email Address: ____________________   Cell Phone: _________________________

Anticipated Year of Graduation: ______________

Please check the requested accommodation(s):

_____Wheelchair accessible room
_____Ground level room
_____Elevator access
_____Private room (single)
_____Approval of restricted appliance (i.e.: air conditioner, microwave, etc.)

If yes, which appliance? ________________________________

_____Visual / Vibrating emergency alert
_____Service animal
_____Live-in assistant

_____Other: ________________________________

Are you currently living in St. Bonaventure University housing that was assigned for the same reason?

_____Yes   _____No

Are you registered with the Office of Disability Support Services? _____Yes   _____No

If you are a continuing student: Have you renewed your request this year? _____Yes   _____No (if not, why not?)

The Special Housing Needs Form (Section C) must be submitted by your health care provider.

Please note: This request does not guarantee a housing assignment or change in assignment. A final decision on reasonable accommodation(s) will be made in consultation with Health Services, the Office of Disability Support Services, and the Office of Housing & Residential Education.

Revised 5/23/2012
Request for Housing Accommodations  
Section C (to be completed by health provider)  

__________________________ (student name) has requested special housing here at SBU.

You are being asked to provide documentation of disability for your client _____________________________. Please fill out the form below and attach any appropriate supplemental documentation. Thank you in advance for your support and cooperation in this manner.

Provider Name/Title ____________________________________________ Date ________________

Address ______________________________________________________ Fax Number: ____________________________

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who:
(1) Has a physical or mental impairment which substantially limits one or more major life activities, or
(2) Has a record of such an impairment, or
(3) Is regarded as having such impairment.

“Major life activities” are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one’s self, performing manual tasks, reproduction, and working.

1. Natures of disability (Formal Diagnosis) please include expected duration.

___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Date of most recent assessment of this diagnosis: ________________________________

2. Severity of condition. (Mild, Moderate, Severe) ________________________________

3. Check all relevant functional limitations that are substantially limited.

   _____Walking  _____Hearing  _____Seeing  _____Working  _____Sleeping  _____Caring for self
   _____Interacting with others  _____Learning (including memory/concentration)  _____Climbing Stairs
   _____Performing manual tasks  _____other, please describe ____________________________________________

Revised 5/23/2012
4. Please explain how each functional limitation will specifically affect your client’s ability to live in the Residence hall:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

5. List current medication(s), dosage, frequency, and adverse side effects for this diagnosis:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

6. Please suggest reasonable accommodations. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

7. Please state alternatives to meet the documented need if the first request cannot be met.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

8. Please discuss the impact on your client’s disability if the accommodation cannot be granted.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

9. Additional comments:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Please note: All activities for assessment of special housing needs is in accordance with section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.(see first page). All final decisions on which reasonable accommodations will be granted are made in consultation with the Office of Disability Support Services, Office of Residential Living and Housing, Health Services, or other offices as needed on a case-by-case basis. At no time is housing assignment guaranteed.

____________________________________________________________________________________

Signature of Provider                                                                                                     Date

Please return the completed form and supplemental documentation to:
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St. Bonaventure University
PO Box BZ
St. Bonaventure, NY 14778
Fax: 716-375-2647