Housing Request for Medical Reasons

If a student has circumstances that warrant a special request for housing, the request must be made to the Disability Resource Center. Students with documented disabilities are entitled to reasonable accommodations as per the Americans with Disabilities Act (ADA). Please do not send this documentation to the Office of Housing and Residence Life.

Please review the following guidelines and submit the attached form along with all pertinent documentation to the Disability Resource Center by email or fax. Return students must submit requests prior to when fall housing assignments are made. New students should submit requests by the end of May, which is typically when fall housing assignments are made for freshmen and transfer students.

Instructions to Student:
2. Have your health care provider complete the form on page three and have them send it directly to DRC@uncw.edu along with any supporting documentation to the Disability Resource Center.
3. Submit a personal statement of need regarding your housing requests and provide details about what the need is as well as support for the request.

Decision Process:
- The Housing committee will review the request and inform you if additional information is needed. All requests will be given due consideration, as per the Americans with Disabilities Act (ADA) guidelines of reasonable accommodations.
- The Director of Housing and Residence Life or designee will contact the student to inform him/her once a decision has been made regarding their housing status.
- The Office of Housing and Residence Life attempts to meet the request of all students. However, given the limited inventory of housing, not all requests will be granted, nor does this process guarantee a reservation of space.

Additional Notes:
- Students with medically documented dietary needs will need to meet with the Director of Dining Services first to discuss if their needs can be met.
RELEASE OF INFORMATION

I, (student print name) __________________________________________ hereby authorize the release of the following information to the Disability Resource Center (DRC) at University of North Carolina Wilmington for the purpose of determining my eligibility for a housing accommodation. This information may include medical and/or psychiatric care and treatment.

_________________________  __________________________
Student Signature                  Date

_________________________
UNCW 850 #

_________________________  __________________________
Academic Year                  Student Classification: (Circle all that apply)

Freshman  Sophomore  Junior  Senior  Transfer

Student Housing Request: __________________________________________

Example: Request to live off campus, single room, single bathroom, kitchen to prep meals, dietary needs, etc., other?
Date of last visit: ________/________/_______

Diagnosis/Condition: ________________________________________________________________

Recommendation related to the specific housing request:
__________________________________________________________________________________

Example:  Request to live off campus, single room, single bathroom, kitchen to prep meals, dietary needs, etc., other?

Does provider agree with the student’s request listed above?  Yes____ No ____

Does the student experience any functional limitations related to University housing? Yes ___ No ____

If yes, please describe the limitations:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Please state your specific recommendations regarding the housing accommodation(s) this student needs. Indicate how the accommodations would assist the student with their functional limitations:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Health Care Provider’s name: ______________________________________________________________________

Health Care Provider’s signature: ____________________________________________________________________

Date: _____/______/______      Phone:    _______________________________________________

License Type: ________________________________  License  _____________________________________

Address: _______________________________________________________________________ ___________________

*Note: The details of this documentation will not become part of the student’s academic record.