Verification Form for Housing Accommodations at OBU

Student's Name:_____ OBU ID#_____
Current or anticipated OBU housing location (Building and room #): _____

I authorize the ADA 504 Accommodations Coordinator of Ouachita Baptist University (OBU) to receive information from my provider (name)_____. I also authorize my provider to discuss and/or disclose my condition(s) and treatment history with the appropriate and qualified OBU personnel on an as needed basis. I understand that all documentation submitted to this office is considered confidential, but may be discussed, as needed for consultation and if appropriate, with the OBU Housing Director and/or the Campus Physician, Wesley Kluck, MD.

Student's Signature:_____ Date:_____

In order to determine reasonable accommodations for housing, OBU requires current and comprehensive documentation of the student's condition from a licensed clinical mental health professional or the student's current treating health care provider. **If an ESA is being requested, or the basis for the requested housing accommodation is a mental health condition, this form MUST be completed by the student's current treating mental health provider**, and not by his/her general healthcare physician or PCP. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information. This form's completion and submission does NOT guarantee that a request will be granted. **Student, be advised** that an Emotional Support Animal (ESA) will not likely be granted a student who is not currently attending psychotherapy to address his/her mental health condition, and has for at least three months, involving weekly or bi-weekly treatment sessions provided by a licensed mental health clinician.

The deadlines for current students submitting a request for fall housing accommodations are as follows:

- **March 16th for students in OBU Residence Halls or OBU owned apartments**

The remainder of this form must be completed by the licensed clinical mental health professional or health care provider currently treating the student, and who is familiar with the history and functional limitations of the student's current disabling condition(s). This professional may NOT be a relative of the student.

Name of professional completing form: _____
Qualifications/Credentials: _____
Relationship to above named student (Clinician cannot be a relative of the student): _____
1) Date of Initial contact with student: ___/___/_____ **2)** Date of student's last office visit: ___/___/_____
3) Nature and frequency of the clinician's treatment interaction with the student (e.g., "Weekly/bi-weekly sessions for the past 6 months", "Two sessions with the student", "PCP" or "Medication management only")
_____
4) Student's medical or mental health diagnosis (title and ICD-10 codes) _____
_____
5) Clinician: Do you assert or affirm that the above named student has a current medical or mental health diagnosis or condition (if not yet diagnosed) which creates symptoms so severe that it substantially limits or impairs the student's functioning in at least one or more major life activities? (Circle one) **Yes / No**
6) Approx. onset of diagnosis: ____/____/_____ Symptom(s) severity: __mild __ moderate __ severe
Prognosis of disorder: ___ good ___ fair ___ poor Expected duration of medical condition:_____
7) It is not sufficient to assert that a student will "benefit" from a particular suggested accommodation. For any condition to be identified as a disability, it must create such severe symptoms or restriction to the person's daily functioning that it substantially limits one or more major life activities. Please describe the symptoms related to the student's condition that cause significant impairment in a **major** life activity.
_____

_____

_____

8) If a mental health condition is at the core of the student's disability, please list the interventions that have already been applied to the patient's condition to help alleviate or reduce its debilitating effects, though with inadequate results, thereby necessitating additional housing accommodations (e.g., psychotropic or other appropriate medications, 3 months of CBT, Exposure Therapy, DBT, EMDR, modified academic schedule, etc.).

a) _____

b) _____

c) _____

9) Is the requested housing accommodation something that may benefit the student's functioning, or is it clear that it is an **essential necessity** to the student's functioning? If the latter, how was this judgement made? What evidence exists to support that conclusion?

_____

_____

_____

10) If a private room is what is being requested, would a well-matched, considerate, and reasonably mature, accommodating roommate be a suitable alternative response to the student applicant's need? _____

11) Please state the clinician's specific housing related accommodation recommendation(s), based upon the student's disability (if the student suffers from a mental health related disability, please explain and affirm how the requested accommodation will alleviate a specific disabling symptom of the student's condition).

_____

_____

_____

12) Anticipated duration of requested accommodation (include explanation if longer than 2 semesters, unless condition is permanent/lifelong): ____ 1 Semester ____ 2 Semesters ____ Entire OBU education *(this duration of accommodation will not be granted for many mental health conditions)*

Explanation: _____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or postal mail to our ADA 504 Accommodations Coordinator at the address or fax number below.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above, and that all of the information on this form is accurate.

Signature: Signature: _____Date: ____/____/_____

Print Name and Title: _____

State of License: _____License Number: _____

Office Address: _____

City: _____ State: ____ Zip Code: _____

Phone:_____

Fax:_____

Provider, please fax or email this completed form, FROM YOUR OFFICE, to:

Daniel Jarboe
Counseling Services & ADA 504 Coordinator
Ouachita Baptist University
410 Ouachita, Box 3646
Arkadelphia, AR 71998-0001
Fax: (870) 245-5341 Email: jarboed@obu.edu

Please attach clinician's business card here