



Return form and relevant documentation to:
Office of Student Accessibility Services
Illinois Wesleyan University
PO Box 2900, Bloomington, IL 61702-2900
accessibility@iwu.edu
309-556-3231 (phone), 309-556-3436 (fax)

Housing/Meal Plan Accommodation Request

Students with diagnosed disabilities or medical/mental health conditions whose needs cannot be met through the standard room selection process and the standard meal plan options may request a housing and/or meal plan accommodation. To determine eligibility, current and comprehensive documentation of a disability(ies) or medical/mental health condition(s) from the diagnosing/treating physician or other qualified professional is required. Submission of a request does not guarantee approval of an accommodation.

Student's Name: _____ Date of Birth: _____

Academic Year Requesting For: 20 ____ - 20 ____ IWU ID #: _____

1. Provide a complete medical, ICD-10, or DSM-5 diagnosis(s). If this condition is temporary, provide an anticipated duration.

Four horizontal lines for providing a complete medical, ICD-10, or DSM-5 diagnosis(s).

2. Date of diagnosis: _____

3. Length of time you have treated this student; specify dates: _____

4. Date of last contact with student: _____

5. Describe symptoms, frequency, and severity of symptoms the student currently has that meet the criteria for this diagnosis(s).

Three horizontal lines for describing symptoms, frequency, and severity of symptoms.

6. List current treatments, including therapy, assistive devices and medication (include dosage, frequency, and adverse side effects). Please include the degree to which symptoms have reduced with treatment.

Three horizontal lines for listing current treatments.

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7. Describe if and how the diagnosis(s) substantially impacts the student's level of functioning.

8. State your specific recommendations regarding a housing and/or meal plan accommodation(s) **with a rationale** that is based on the student's academic and life functioning as to why this housing/meal plan accommodation(s) is warranted based upon the student's diagnosis(s).

9. Please indicate if/which of your recommendations you believe are medically necessary and **provide a rationale.**

10. How would not receiving these recommendations affect the student's academic and life functioning?

I verify that the above-named student information is correct, the student is a patient or client that I have been treating, and I am not a relative of the student.

Print name and title: _____ License or NPI Number: _____

Street Address: _____ City, State, Zip: _____

Telephone No.: _____ Email: _____

Signature: _____ Date: _____