

REQUEST FOR HOUSING ACCOMMODATIONS

Instructions:

This form is to be used for students requesting accommodations from Harvard Law School (HLS) Housing or Harvard University Housing (HUH) only. Students who are requesting Harvard University Housing (HUH) should also visit <http://www.huhousing.harvard.edu> for additional information about requesting housing through HUH. Students requesting to live off-campus do not need to complete this form.

The attached Statement from Medical Provider form should be completed by your current doctor or treating practitioner. A detailed letter or documentation currently on file with Accessibility Services may also stand in lieu of the form. Documentation will be reviewed and reasonable accommodations will be determined by Accessibility Services. Documentation must:

- a. Satisfy the documentation guidelines for the student's diagnosis type
- b. Include information about the accommodations being recommended
- c. Provide a rationale for each recommended accommodation

Please note: All students requesting housing accommodations must meet all standard housing procedures, requirements and deadlines.

To be completed by student:

STUDENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Harvard University ID (HUID): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Local Address: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Other: \_\_\_\_\_

Harvard Email Address: \_\_\_\_\_ Alternate Email Address: \_\_\_\_\_

ACADEMIC INFORMATION

IL    2L    3L    LLM    SJD    Visiting    Other (please specify) \_\_\_\_\_

Dual Degree (please specify): \_\_\_\_\_

REQUEST FOR HOUSING ACCOMMODATIONS

REQUESTED ACCOMMODATIONS:

- Single Room
- Wheelchair Accessible Unit
- Semi-private Bathroom (e.g. shared bathroom in an apartment)
- Private Bathroom
- Strobe Alarm (flashing alarm)
- Service or Assistance Animal
- Proximity to Campus
- Air Conditioned Unit
- Furniture Requests (e.g. furniture removal)
- Other: \_\_\_\_\_

RELEASE OF INFORMATION:

Student Name: \_\_\_\_\_ Harvard University ID: \_\_\_\_\_

I give permission to the individual(s) or organization(s) named below to release medical information related to disability or medically- related accommodations to Accessibility Services at Harvard Law School and also to receive information from Accessibility Services.

\_\_\_\_\_  
\_\_\_\_\_

I agree that:

1. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization.
2. I may revoke this authorization at any time by notifying Accessibility Services at Harvard Law School. However, such revocation will not affect any actions taken before the revocation was received or actions taken on reliance thereon.
3. I understand that information on file at Accessibility Services is protected under the Family Educational Rights and Privacy Act (FERPA).
4. I understand that my healthcare provider may also have his or her own form that I may need to complete to allow the release of medical information.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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To be completed by the medical professional:

STATEMENT FROM MEDICAL PROVIDER

This form is intended to be used for determining reasonable accommodations for a student requesting disability-related housing accommodations through Harvard Law School (HLS). Please complete the requested information in as much detail as possible. The information obtained will be used for sole purpose of determining reasonable accommodations. A signed consent has been completed and is on file at Accessibility Services at Harvard Law School. Please feel free to contact [accessibility@law.harvard.edu](mailto:accessibility@law.harvard.edu) or 617-495-8773 with any questions.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

A. Provider's Information

Medical Professional's Name: \_\_\_\_\_

Certification/Credentials: \_\_\_\_\_

State Licensure and Number: \_\_\_\_\_

Agency or Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

B. Diagnostic Information

Specific diagnosis(es) related to the requested accommodations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of diagnosis or date of onset: \_\_\_\_\_

Most recent evaluation or visit: \_\_\_\_\_

REQUEST FOR HOUSING ACCOMMODATIONS

How long is this condition likely to exist? \_\_\_\_\_

Please describe the student's functional limitations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the student's functional limitations impact their housing needs? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any current medications and potential side effects related to the functional limitations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the recommended housing accommodation(s) and rationale for the recommended accommodations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_