



## Student Access & Resource Center

### Verification Form for Housing and Dining Accommodations

*This section to be filled out by student seeking the accommodation:*

Name \_\_\_\_\_ ID# \_\_\_\_\_

I am requesting the following **HOUSING** accommodation:

1 – Housing request for an Assistance (emotional support) Animal: Dog  Cat  Other: \_\_\_\_\_

*Note: All approved service or assistance animals must comply with applicable laws regarding animals, including the City of Arlington Code of Ordinances regarding animals and campus grounds pet policies.*

2 - Housing request for a single room: Yes  No

3 - **Other** Housing request: \_\_\_\_\_

I am requesting the following **DINING** accommodation:

\_\_\_\_\_

*Please specify what type of alteration to the dining plan is needed.*

I authorize The University of Texas at Arlington, Student Access & Resource Center to receive documentation and speak to my current, licensed clinical professional or health care provider, \_\_\_\_\_.

*Print Name of Medical Provider*

**Student signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### ***Information for Students seeking accommodations and medical providers:***

The Student Access and Resource Center complies with all federal and state disability laws to ensure equal access for qualifying individuals with a disability to educational programs, services, and activities. Registration with the SAR Center as a student with a disability and a complete intake appointment is required.

In order to determine reasonable accommodations for housing, the SAR Center requires current and comprehensive documentation of the student’s condition from their treating licensed clinical professional or health care provider.

**The qualified provider must be thoroughly familiar with the student’s condition and functional limitations and must make a direct connection to the requested accommodation based on the student’s current functional limitations.**

**The qualified provider completing this form cannot be a relative of the student, must reside within the student’s home state, state of permanent residence or tribal services provider where the student was diagnosed and treated.**

***Internet certificates or any other internet acquired documentation will not be accepted.***

*\*All documentation submitted to the Student Access & Resource Center is considered confidential. The Student Access & Resource Center may share minimal information with appropriate University staff in order to process the request.*

**Please return this form to: The University of Texas at Arlington Student Access & Resource Center  
Box # 19510 University Hall, Room 102 601 Nedderman Drive Arlington, TX 76019-0510**

***This section to be completed by a licensed clinical professional or health care provider:***

Print Name and Title: \_\_\_\_\_  
Credentials: \_\_\_\_\_ Specialty: \_\_\_\_\_  
State of License: \_\_\_\_\_ License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
I certify that I conducted or formally supervised and co-signed the diagnostic assessment of this student.  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Date of initial contact with the student: \_\_\_\_/\_\_\_\_/\_\_\_\_  
2. ***Specific Diagnosis/Disability:*** Please list all relevant diagnoses, including DSM-IV or ICD Diagnoses (**text and code**), and Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Procedure/assessment used to diagnose this condition: (Attach copies of results if needed)  
\_\_\_\_\_

4. **Current Severity of Symptoms:**                      **and**                      **Prognosis of Condition/Disorder:**

mild

good

moderate

fair

severe

poor

5. Date of last office visit with Student: \_\_\_\_/\_\_\_\_/\_\_\_\_  
6. Prescribed treatment or medications:  
\_\_\_\_\_  
\_\_\_\_\_

7. Describe symptoms related to the student's condition that cause significant impairment in a major life activity. Include how this limitation affects the student's ability to participate in student life.  
\_\_\_\_\_  
\_\_\_\_\_

8. State specific recommendation regarding housing/dining, and rationale based upon the student's condition. Indicate why/how the recommended change(s) to the environment are necessary. Recommendations must be clearly linked to functional limitations of the student's condition.  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you. Please return this document to the address below. \*All documentation submitted is considered confidential.*

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