



Northeastern University

Request for Health-Related Housing Accommodation:

Student authorization to clinician

*For students requesting an air conditioner, carpet-free room or personal furniture only. Students making other requests should see www.northeastern.edu/drc

Dear: _____,
(Name of Clinician)

I am requesting the following specific housing arrangement/alteration in my residence hall at Northeastern University:

air conditioner carpet-free room personal furniture (mattress)

In order to be considered for this health-related specific housing arrangement, I must submit the Health-Related Housing Accommodation Form, completed by my treating clinician. The form is attached.

I hereby authorize you to complete the attached form and release it to the DRC
 I also authorize you to speak with DRC staff to provide consultation concerning the requested health-related housing arrangement.

Please submit the completed form to our office
By email: **DRCdocumentation@northeastern.edu**

By mail: Dodge Hall 20
Northeastern University
360 Huntington Avenue
Boston, MA 02115

By confidential fax: 617-373-7800

Thank you for your timely assistance with this matter.

Sincerely,

Student Signature

Date

Print Name

NUID#

Housing Accommodation Request Form

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Students making other requests should see www.northeastern.edu/drc

This form is to be filled out by the student's current treating clinician

1. Patient's/Client's name: _____

2. Diagnosis: _____

3. Please provide full DSM or ICD-10 code: _____

4. Initial date of diagnosis: _____ Date of last clinical contact: _____

5. What is the frequency of the disorder's symptoms for this student?

ongoing episodic (Please indicate frequency and duration below)

6. The extent of the impairment is: Mild Moderate Severe

7. Please explain why the student's health-related condition requires the housing accommodation he/she indicated on the cover sheet.

8. Certification

Clinician's name: _____

Clinician's state licensure/certification #: _____

Area of specialty: _____ Clinician's phone #: _____

Clinician's signature

Date