Office of Accessibility
Sacred Heart Hall 303
1247 East Siena Heights Drive
Adrian, MI 49221
Telephone# 517-264-7683
Fax# 833-413-2849

AIR CONDITIONER REQUEST DUE TO A DISABILITY

Name		
Date of Birth	SID #	Cell Phone Number

This Air Conditioner Request Form is to be thoroughly completed and returned to Health Services. Incomplete forms will not be reviewed.

This Form is to Be Completed by a Licensed Physician or Medical Specialist:

Please respond to the following questions regarding the student named above:

1.) Please indicate when you first started seeing the above-named patient for the impairment/condition described in this form:

____
____
____

2.) As per the American with Disabilities Act, please indicate whether the student has a physical or mental impairment that substantially limits a major life activity, and if so, what the condition is, what major life activity is substantially limited by it, and how the major life activity is substantially limited by the impairment:

____
____
____

5.) What is the severity of the condition?

____
____
____

6.) How long is this condition likely to persist?

____
____
____

7.) Describe the symptoms related to the student's condition, if any, that cause significant impairment in one or more major life activities and which would support the student's request for the accommodation being requested:

____
____
____

8.) Please identify any prescription and/or over the counter medications taken to manage symptoms with frequency of the dose.

____
____
____

9.) Are allergy injections given? Yes _____, or No _____

- If Yes: what type and frequency:
  ____
  ____

10.) Are the symptoms: Continuous _____, Intermittent_____ or Seasonal_____?

11.) Are the symptoms: Mild _____, Moderate _____, or Significant _____?

12.) Is the use of an air conditioner: Desirable_____ or Essential_____ to participate in the College's residential program?

13.) In your opinion, how important is it for the student's well being to have the accommodation being requested? (1 = not important, 5 = critically important). ___________

The provider may also send a report that provides additional related information. **The provider completing this form cannot be related to the student and must practice in the specialty area related to the condition identified.**

Signature of Provider:____Date: ________________

Address: ____

City:____________________State:____________ ***Affix Office Stamp Below***

Telephone #: ______________________________

Fax #: ______________________________

OFFICE USE ONLY

Request Reviewed: Date _______________ Approved________Denied: ________

By____

Student Notified: Date____ By: E-Mail_______Letter__________

Residence Life Notified: Date ________________________________ By: E-Mail_______Letter_________

Clinic Notified: Date _______________________________________ By: E-Mail_______Letter__________