



Office of Accessibility
Ledwidge 160
1247 East Siena Heights Drive
Adrian, MI 49221
Telephone# 517-264-7651
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 _____