



RUTGERS-NEW BRUNSWICK
Residence Life
 Division of Student Affairs

Residence Life
 Davidson Hall D-Busch Campus
 Rutgers, The State University of New Jersey
 90 Davidson Road
 Piscataway, NJ 08854

<https://ruoncampus.rutgers.edu/housing-info/special-accommodations>
oncampus@echo.rutgers.edu

P: 848-445-0750

Medical Housing Accommodation Request Form for Healthcare Professionals

This request form is to be completed by the treating healthcare professional of the Rutgers University-New Brunswick student requesting medical housing accommodations. Students may not complete this form on behalf of their treating healthcare professional. Treating healthcare professionals should answer all questions fully and include a signature and office stamp at the bottom of the form. Incomplete forms will not be accepted.

Any questions or concerns may be forwarded to:

Residence Life-Special Accommodations
 Davidson Hall D - Busch Campus
 Rutgers, The State University of New Jersey
 oncampus@echo.rutgers.edu
 P: 848-445-0750

Student's name _____

What is the student's relevant medical diagnosis?

Date of diagnosis:

Date of last office visit: _____

The condition is (circle one):

- Permanent
- Temporary

If temporary, what is the anticipated duration? _____

Prescribed medications(s) (please indicate dosage):

Please describe the type, severity, and frequency of symptoms currently experienced by the student and how the condition interferes with one or more major life activities:



Please describe the desired housing accommodations and explain how the request relates to the impact of the condition:

How will the student manage these symptoms in other campus settings (i.e. classrooms, dining halls, libraries, etc.)?

Please indicate how this student may be a risk during an emergency evacuation (i.e. fire):

Healthcare Professional's Contact Information

Name of Provider: _____

License Number: _____

Telephone Number: _____

Please place treating healthcare professional's stamped contact information in the space provided. If treating healthcare professional does not have a stamp, submitting letterhead will be accepted in its place. If left blank, form will not be accepted.

Signature: _____ Date: _____

My signature verifies that I am the treating healthcare professional and that the contents of this form are accurate. The healthcare provider completing this form cannot be a relative of the student