The Student Disability Resource Center (SDRC) at Florida State University (FSU) complies with all federal and state disability laws to ensure equal access for qualifying persons with a disability to educational programs, services, and activities. Please complete the form below to assist the SDRC in determining appropriate and reasonable disability accommodations for housing. To be considered for a housing accommodation due to a disability, FSU requires documentation of the student’s current condition from the treating licensed clinical professional or health care provider. This 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. Please complete this form in total. Additional paper may be attached if the space provided is inadequate.

**Student Name:**

1. Specific diagnosis/disability (include diagnostic code) ____________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

2. Date of diagnosis __________________________________________________

3. Procedure/assessments used to diagnose this condition (Attach copies of results)
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

4. Current severity of this condition________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

5. Expected duration of this condition_______________________________________

6. Date of last office visit for this condition_____________________________________

7. Prescribed treatment or medications_______________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

Updated 04/2017
8. Describe how this condition substantially limits a major life activity.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

9. How will this limitation(s) affect the student’s ability to participate in student life, specifically housing and academics?  ________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

10. Recommended housing accommodation – please be specific. Recommendation must be clearly linked to functional limitations.
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

11. Why is this accommodation necessary for their condition?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

12. An alternative if the recommended housing accommodation is not available:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

SIGNATURE OF PHYSICIAN/CLINICIAN:  
__________________________________________________________________

CREDENTIALS_____________________    SPECIALTY_______________________
LICENSE/CERT. #___________________________________   STATE___________
DATE__________________________________

*Please attach your business card.

Updated 04/2017