



Verification of Disability Form- Housing Accommodations  
Lakeland University

**Student:** Please have your medical doctor, clinical/counseling psychologist or other qualified care provider complete this form or use it as the basis for their narrative summary.

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(Student's Full Name)

(Student's Social Security Number)

Section 504 of the Federal Rehabilitation Act (1973), the Americans with Disabilities Act (1990, 2008), and the Housing and Urban Development (HUD) Fair Housing Act (1968, 1988, 2020) require that colleges and universities do not discriminate against otherwise qualified applicants and students with documented disabilities. Lakeland University recognizes the importance of providing reasonable accommodations in its housing policies and practices where necessary for individuals with disabilities to fully participate in the housing program.

The above-named student has indicated that you are the health care provider who can verify that a housing accommodation will have therapeutic benefit in mitigating one or more of the symptoms or effects of the student's disability, so that the student may have an equal opportunity to use and participate in University housing.

Federal law defines a person with a disability as someone who has a physical or mental health impairment that *substantially limits* one or more major life activities. So that Lakeland University can fully evaluate and consider the student's request for a housing accommodation, please answer the following questions:

**Diagnostic Information:**

DSM-V Diagnosis of ADD/ADHD, or LD must be made by a:

- Ph.D. level Clinical or Counseling Psychologist
- Medical Doctor
- State-licensed and certified School Psychologist (for Educational Diagnosis)

Diagnoses of depression, anxiety and other psychological disorders must be made by a:

- Master's or PhD level Clinical or Counseling Psychologist or Social Worker
- Medical Doctor



Diagnoses of physical or medical conditions that substantially interfere with a major life function must be made by a licensed medical doctor. The diagnosis must be current, (i.e. within the last three years) unless the Disabilities Office extends the time period, or the disability documented is of a permanent and unchanging nature.

1. Diagnosis: \_\_\_\_\_  
(provide relevant DSM-5 or ICD-10 information)

2. Level of severity: \_\_\_\_\_ Mild      \_\_\_\_\_ Moderate      \_\_\_\_\_ Severe

3. Date of diagnosis: \_\_\_\_\_

4. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability.

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5. Please identify the measures (e.g. prescriptions, treatment, therapy, etc.) the student is using to assist in mitigating the limitations caused by their disability.

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6. Per your recommendation, what accommodation(s) are reasonable and necessary to allow the student to use and participate in University housing?

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7. Please explain how the recommended accommodation(s) are necessary for the student to use and participate in University housing as compared to a person without a disability.

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**Certifying Authority:**

Printed Name and Title: \_\_\_\_\_

Signature: \_\_\_\_\_

License # and State: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_



The information requested here is critical for processing your patient's request for a housing accommodation. Incomplete verification or lack of information may result in the approval process being delayed or denied. If you have questions about the information requested or how the information will be used, please contact Karen Eckhardt, ADA Coordinator, at 920-565-1021 ext. 2115. Following completion of this form, or a narrative summary based on this form, please return it to:

Karen Eckhardt, ADA Coordinator  
Lakeland University  
W3718 South Drive  
Plymouth, WI 53073  
FAX: 920-565-1068  
Email: EckhardtKL@lakeland.edu

**Student:**

By signing below, I consent to allowing my health care provider to share any information relevant to my request for a housing accommodation, as shown on this form.

I understand that all requests for housing accommodations are subject to an annual review. Documentation will be needed each academic year to continue to evaluate that the need for an accommodation continues to be part of my ongoing treatment plan.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_