

**Auburn University**  
**HOUSING ACCOMODATION REQUEST FORM**  
(Please print in blue or black ink)

Student's release (please print):

I \_\_\_\_\_,  
Authorize my physician, psychologist, or counselor, \_\_\_\_\_ to provide  
information and answer questions regarding my medical and/or psychological condition to Auburn  
University Housing in order to determine my eligibility to receive a requested accommodation within  
on-campus housing. A letter *from your treating clinician*, on their letterhead, stating the diagnosed  
medical condition and the suggested housing accommodations is required in order for you to be  
considered for needs based Housing accommodations. Please have them also provide the information  
on the following page.

**Please fill in the applicable information that is required for the room accommodation request.**

**Student Name (print):** \_\_\_\_\_ **Student ID # 90** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Email Address:** \_\_\_\_\_

**Accommodations Requested:** \_\_\_\_\_

It is a violation of the Code of Student Discipline to furnish false information to Auburn University.  
A student who furnishes false information to the University will be required to make restitution and  
may face other penalties as appropriate.

---

**All documents must be submitted by March 31<sup>st</sup>.**

**Please mail or deliver the application and supporting documentations to:**

**Auburn University Housing  
Burton Hall  
305 West Samford Ave  
Auburn University, AL 36849**

For additional information regarding special housing accommodation requests, please contact the  
Housing Office at (334) 844-4580, or visit the website at [www.fp.auburn.edu/housing/](http://www.fp.auburn.edu/housing/)

***Dear Treating Medical/Psychological Professional:***

This student is requesting an accommodation within Auburn University housing due to his/her medical and/or psychological condition. Please provide the following information with supporting medical documentation so that we can best accommodate this request. The following medical information will be reviewed by a committee consisting of the Director of the AU Medical Clinic, the Director of the Program for Students with Disabilities and the Director of University Housing.

---

Your Specialty: \_\_\_\_\_

Your business address: \_\_\_\_\_

\_\_\_\_\_  
(city) (state) (zip code)

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

Diagnosis: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Frequency: ☐ Daily ☐ Weekly ☐ Monthly

Other (explain): \_\_\_\_\_

Anticipated Duration: From \_\_\_\_\_ To \_\_\_\_\_ ☐ Chronic ☐ Temporary

Severity of Condition: ☐ Mild ☐ Moderate ☐ Severe

Current Medications: \_\_\_\_\_

Limitations: \_\_\_\_\_

Appliances or Medical Aids Needed: \_\_\_\_\_

While controlled on medication, check any of the following which are problematic for this student given his/her diagnosis:

☐ Breathing ☐ Stairs ☐ Hills ☐ Walking (more than 2 blocks) ☐ Humidity ☐ Allergens

Date of Last Appointment: \_\_\_\_\_ Next Appointment (if scheduled): \_\_\_\_\_

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

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Auburn University and Auburn University Housing complies with all Health Insurance and Accountability Act (HIPAA) regulations.*