Housing Accommodation Verification Form

To be completed by Licensed Healthcare Professional:

1. Is the resident a person with a disability (defined as having an impairment that limits one or more major life activities for longer than 6 months)? You do not need to provide detailed information about the nature or severity of the specific disability.   ☐ YES   ☐ NO

2. Please describe how this disability restricts or limits the resident in conducting one or more major life activities:

3. Does the student require the above requested accommodation to have an equal opportunity to use and enjoy their housing?   ☐ YES   ☐ NO

4. If yes, please describe the connection between the current limitations and the requested accommodation in order for the resident to have an equal opportunity to use or enjoy their housing

---

To be completed by Resident:

Resident Name:____________________________________________ Student ID#:____________________________________________

Relationship to Student:____________________________________________

Telephone#:____________________________________________ Email:____________________________________________

Housing Accommodation Request:_____________________________________________________________________________

Resident Signature:_____________________________________________________________________________

This signature authorizes the verifier below to provide answers to the questions to the best of his/her knowledge of this resident, solely for the purpose of determining the disability-related need for the housing accommodation requested.

---

Name of Physician or Certified/Licensed Professional: ______________________________________________________

Organization:____________________________________________ Title:____________________________________________

Phone Number:____________________________________________ License or Certification #:____________________________________________

*I verify that the above information is complete and accurate to the best of my knowledge and certify based upon professional ethics that I am not related to this resident.

Signature:____________________________________________________________________________

Date:____________________________________________________________________________

Please attach business card at top.
Application for Reasonable Accommodations for University Housing

If you require assistance completing this form, or require an alternative format, please contact the Disability Services Center at 949-824-7494. UCI will keep a record of all requests.

Student Name:_________________________________ Student ID#________________________________
Housing Community:___________________________ Unit #:________________________________
Email:_______________________________________ Phone:________________________________
Person Requesting Accommodation:__________________________________________________________
Relationship to Student:_____________________________________________________________________

Accommodation Request:
1. I am a person with a disability (defined as having an impairment that limits one or more major life activities for longer than 6 months). You do not need to provide detailed information about the nature or severity of the disability.  □ YES  □ NO

2. I require the following housing exception because of my disability:
   □ Physical Change to Unit
   □ Other______________________________________________________________

3. In order to have an equal opportunity to use or enjoy University Housing, please describe the connection between your current limitations and the requested accommodation. (You do not have to disclose your specific disability).

Signature:__________________________________________ Date:____________________
Application for Reasonable Accommodations for University Housing

☐ Physical Space Changes:
If you are requesting a physical change to the interior of your assigned unit, please describe the needed modifications:

☐ Other Accommodation Requests: (Please Describe)