# Request for Housing and Dining Accommodations

This page to be filled out by the student seeking the accommodation.

| Name ______________________________ | R# __________________________ |

I am requesting the following **HOUSING** accommodation:

1 - Housing request for an Assistance (emotional support) Animal: **Dog** | **Cat**

*Note: All approved service or assistance animals must comply with applicable laws regarding animals, including the City of Lubbock Code of Ordinances, Chapter 4- Animals.*

2 - Housing request for a single room: **Yes** | **No**

3 – **Other** Housing request: __________

I am requesting the following **DINING** accommodation:

Please specify what type of alteration to the dining plan is needed.

I authorize Texas Tech University Student Disability Services to receive documentation and speak to my current, licensed clinical professional or health care provider, __________.  

*Print Name of Medical Provider*

Student signature: ____________________________ Date: __________

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**Information for Students seeking accommodations and medical providers:**

Student Disability Services at Texas Tech University 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 this form to assist Student Disability Services in determining appropriate and reasonable disability accommodations. To be considered for a housing or dining accommodation due to a disability, Texas Tech University 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. This provider may not be a relative of the student, and the provider must be licensed within the student’s home state or state of permanent residence where the student was diagnosed/treated. Please complete this form in total. Additional paperwork may be attached if the space provided is inadequate.

*All documentation submitted to Student Disability Services is considered confidential. Student Disability Services may share minimal information with appropriate University staff in order to process the request.*

Please return this form to: Texas Tech University Student Disability Services  
335 West Hall/Box 45007 Lubbock, Texas 79409-5007 T: 806-742-2405 F: 806-742-4837
Please return this form to: Texas Tech University Student Disability Services  
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This page to be filled out by the student’s primary health care provider.

<table>
<thead>
<tr>
<th>Print Name and Title:</th>
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<td>Credentials:</td>
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I certify that I conducted or formally supervised and co-signed the diagnostic assessment of this student.

Signature: ____________________________  Date: ____________________________

1. Date of Initial Contact with Student: _______ / _______ / _______.

2. **Specific Diagnosis/Disability**: Please list all relevant diagnoses, including DSM-IV or ICD Diagnoses (text and code), and Date of Diagnosis: _______ / _______ / _______.

3. Procedure/assessment used to diagnose this condition: (Attach copies of results if needed)

4. Current Severity of Symptoms and Prognosis of Condition/Disorder:
   - □ mild
   - □ moderate
   - □ severe
   - □ good
   - □ fair
   - □ poor

5. Date of last office visit with Student: _______ / _______ / _______.

6. Prescribed treatment or medications:

   _________________________________________________________

7. Describe symptoms related to the student’s condition that cause significant impairment in a major life activity. Include how this limitation affects the student’s ability to participate in student life.

   _________________________________________________________

8. State specific recommendations regarding housing/dining, and rationale based upon the student’s condition. Indicate why/how the recommended change(s) to the environment are necessary. Recommendations must be clearly linked to functional limitations of the student’s condition.

   _________________________________________________________

Thank you for completing this document. Return information below. All documentation submitted is considered confidential.