Housing Requests for Medical Reasons

Please review the following guidelines and return the attached forms along with all pertinent documentation to the Wellness Center located on the 3rd floor of University Crossing.

Instructions to Student:

1. Complete the second page of this form.
2. Sign the Release of Information on the top of the third page of this form.
3. Have your health care provider complete the bottom of the third page of this form.
4. Submit all completed forms along with any supporting documentation to the Wellness Center located on the 3rd floor of University Crossing.

Decision Process:

- The Wellness Center will review the request and consult with the health care provider if necessary.
- The Wellness Center and/or Office of Residence Life will contact the student to inform him/her once a decision has been made regarding their housing status.
- The Office of Residence Life attempts to meet the request of all students. Priority Consideration is given on a first-come first-serve basis. However, given the limited inventory of housing, not all requests will be granted, nor does this process guarantee a reservation of space.

Additional Notes:

- Special Housing Requests are reviewed by June 15 for each fall semester, and January 15 for each spring semester. Late requests will be reviewed bi-weekly.
- Air conditioners must be floor standing models; window units are not allowed. The University will not provide air conditioning units to students.

Appeal Process:

- If the student is not satisfied with the outcome and wishes to appeal the final decision, a written appeal can be submitted the Assistant Dean of Student Affairs for Health and Wellness. Appeals can be delivered to the Wellness Center.
Housing Requests for Medical Reasons (to be completed by student)

Student Information

Name: _____________________________________________

Student ID #: ________________________________

Address: ___________________________________________________________________________

Contact Phone #: ______________________________ E-Mail Address: __________________________

Health Care Provider's Information

Name: _____________________________________________

Address: ___________________________________________________________________________

Contact Phone #: ______________________________

Contact Fax #: _______________________________

Please indicate your housing needs:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Documentation

The University will make every effort to reasonably meet your request. Special housing modifications are limited. Submission of this form and supporting documentation does not guarantee that your request will be met.

Please forward all documentation along with this form and release to:

The Wellness Center
University of Massachusetts Lowell:
University Crossing 3rd Floor
220 Pawtucket Street, Suite 300
Lowell, MA 01854-5144
Attention: Housing Request
Housing Requests for Medical Reasons – CONFIDENTIAL

RELEASE OF INFORMATION (TO BE COMPLETED BY STUDENT)

I, _______________________________ hereby authorize the release of the following information to the
(student, print name)
Wellness Center staff at University of Massachusetts Lowell for the purpose of determining my eligibility for
special housing. This information may include psychiatric care and/or treatment.

UML ID#                                      Date                                      Signature

(TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER)

Diagnosis(es):
Diagnostic code(s) (ICD or DSM IV):
Level of Severity:
Date of Diagnosis:
Date of Hospitalization(s):
Date of Surgery (ies):
Date of last visit:
Current Medication(s):
Currently under treatment?
Expected recovery/rehabilitation time:

Please specify in detail how this problem requires specialized housing:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Thank you for your help in providing this information. Please provide us with contact information, should we need
further information or to verify any of the documentation.

Provider’s Name:______________________________
License #:____________________________________
Address: ______________________________________
Phone: __________________ Fax: __________________
Signature: __________________ Date: ______________

The completed form should be mailed to:

The Wellness Center
University of Massachusetts Lowell:
University Crossing 3rd Floor
220 Pawtucket Street, Suite 300
Lowell, MA 01854-5144
Attention: Housing Request

Note: The details of this medical documentation will not become part of the student’s academic record.