**Special Housing Accommodations Request Form**

**Student Name:** ______________________________

**Banner ID #:** 950-____-____-____

**Cell/Telephone:** (_____) ___-____-____

**Gender:** ☐ Male ☐ Female

**Date of Birth:** __________

**Class Year:** ___ 1st ___ 2nd ___ 3rd ___ 4th or more

**E-mail:** ____________________________

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**NOTE:** To allow for processing, all materials must be submitted at least one (1) month PRIOR to the start of the semester.

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We are committed to providing reasonable accommodations to students with special needs. Students with a documented short/long term medical condition may request special housing arrangements. If you have individual needs or circumstances that warrant special consideration, your request will be reviewed by university officials for approval/disapproval.

Fill out this request form and attach a letter from your doctor on **letterhead** stating the following:

1) Your First Name and Last Name
2) Your Banner ID#
3) Your specific medical condition \ diagnoses \ detailed.
4) A statement from your physician indicated **MEDICALLY NECESSARY** for specific housing arrangement.
5) Physician Signature.

Upon receipt of the requested information the representative of the Student Health Center will review all to determine the medical necessity of the request. The Student Health Center representative will issue a signed recommendation to Housing & Residence Life. After review of the SHC recommendation, the final decision will be made by the Executive Director of Housing & Residence Life.

All materials must be submitted to the Medical Records Office of the Student Health Center via mail or fax to the following address.

**By Mail / Fax**

**Attention Student Health Services**

Student Health Center ~ 1601 E. Market Street ~ Greensboro, NC 27411

phone: 336.334.7880 | fax: 336.256-2613

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**Description of Special Housing Request**

<table>
<thead>
<tr>
<th>Single / Double Room</th>
<th>Refrigerator</th>
<th>First Floor Assignment</th>
<th>Microwave Unit</th>
<th>Other</th>
</tr>
</thead>
</table>

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**Student Health Center Office Use Only**

**Date Received by Student Health Center:** __ ___ / __ ___ / __ ___

**Recommendation of Student Health Center to Residence Life:** Approved ☐ Denied ☐ Referral ☐

**Comments:** ________________________________________________________________

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**Signature and Title of SHC Representative**

_________________________________________ Date __ ___ / __ ___ / __ ___

**Signature and Title of University Representative**

_________________________________________ Date __ ___ / __ ___ / __ ___

Revised 4/17/2015; 7/27/2015