



**Office of Accessibility and Accommodation**

The University of North Carolina at Charlotte  
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# Housing Accommodations Request Form

**Please Read:** UNC Charlotte makes reasonable housing accommodations for students with documented disability needs. **Office of Accessibility and Accommodation (OAA) staff work in conjunction with Housing and Residence Life (HRL) to provide accessible on-campus housing that meets students' disability-related needs.** Requests are evaluated on a case-by-case basis and consider multiple factors. Qualified professionals can submit information on behalf of students.

- Accommodations are based on access and equal opportunity for participation, not on perceived needs, perceived benefit to the student, or preferences.
- **Neither the presence of a disability nor approval for housing accommodations guarantees on-campus housing.**
- Do not use this form to request an Emotional Support Animal.

**Deadlines:** Housing accommodation requests should be submitted by May 1st for the Fall Semester and by November 1st for the Spring Semester. Requests received after the deadline will be reviewed but are subject to availability.

**Submit the Entire Form: Student Section + Provider Section**

## STUDENT SECTION (to be completed by student):

Student Name: \_\_\_\_\_

Student ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\*Note that not including your student ID number and date of birth may delay the process

Which semester do you request that the accommodation(s) begin?

\_\_\_\_\_

Have you been accepted into a Residential Learning Community?      YES    NO

If yes, which one? \_\_\_\_\_

What accommodations are necessary for you to live on campus?

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## Student Consent for Release of Information

**OAA staff may contact my treating provider to verify the information submitted for my request and an exchange of information may need to take place. I give my permission for such communication as necessary with my treating provider named below.**

*\*Please provide the information requested below. **Sign and date the consent.** Failure to provide complete information could slow the processing of your request.*

Treating Provider Name: \_\_\_\_\_

Treating Provider Address: \_\_\_\_\_

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Treating Provider Phone Number: \_\_\_\_\_

I authorize the Office of Accessibility and Accommodation to receive information regarding my disability relative to my housing request from my treating provider.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## TREATING PROVIDER SECTION (to be completed by current treating provider):

**We work in conjunction with Housing and Residence Life (HRL) to provide accessible on-campus housing that meets students' disability-related needs. Disability is defined as a physical or mental impairment that impacts one or more major life activities.**

**Please note the following:**

- Requests should have a direct link between an access issue in on-campus housing and the impacts of a student's disability.
- Diagnosis alone does not automatically qualify the student for accommodations.
- All residence halls have air conditioning.
- Access to a refrigerator and/or microwave can be accomplished without accommodations.
- Roommate selection and assignment are addressed by Housing and Residence Life and their application process, not by OAA.

1. DSM-5-TR or ICD Diagnosis: \_\_\_\_\_
2. Date of initial Diagnosis: \_\_\_\_\_
3. Date of most recent office visit: \_\_\_\_\_
4. Describe in detail the impact(s) of the student's disability as it relates to on-campus communal living. Include the severity and duration of symptoms.

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5. What room configuration would you recommend as necessary to provide disability-related access in on-campus housing? (check all that apply)
  - N/A (all of the options listed below would meet disability-related needs)
  - Traditional shared bedroom
  - Private bedroom with suitemates (does not share a bedroom; shares common living area)
  - Private bedroom with **no** suitemates (does not share a bedroom; no common living area)
6. What bathroom configuration do you recommend as necessary to provide disability-related access in on-campus housing? (check all that apply)
  - N/A (all of the options listed below would meet disability-related needs)
  - In-unit private bathroom (not shared; no roommate)
  - Semi-private bathroom (limited number of users per bathroom)
  - Hall bathroom (shared, communal bathroom)
7. Does the student require an ADA-equipped room or specific egress requirements? (Egress requirements refer to accessibility needs for exiting a building in the event of an emergency.)
  - N/A
  - Wheelchair accessible room
  - Shower with transfer bench
  - Roll-in shower with a shower seat

- Automatic door opener
- Shower with grab bars
- Shower bench
- Adjustable sliding bar shower head with hand-held shower wand
- Lower floors (some stairs)
- Egress floors (no stairs)
- Visual Strobe in Unit for Fire Alarm
- Doorbell with a Visual Strobe in Unit (to notify student of guests)

8. Does the student require a Personal Care Assistant in order to live on campus? This request also requires the student to complete the Personal Care Attendant form which can be found on our [Disability Documentation webpage](#).

- Yes
- No

9.  Student has other accessibility needs that are not listed above. Please explain below:

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10. Explain in detail how the requested accommodation(s) above relate to the student's disability. For the accommodations requested, how will each accommodation mitigate the impact of the student's disability in on-campus housing?

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11. If these accommodations are not available or are not approved, what would be the impact on the student relative to the housing experience?

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### Required Provider Information: To Be Completed by Provider

By signing below, I agree that the information provided above is accurate to the best of my knowledge. I understand that these are accommodation recommendations, that they do not guarantee the student the above recommendations, and that accommodations will be determined by the University's Office of Accessibility and Accommodation.

Medical Provider Signature: \_\_\_\_\_

Medical Provider Name (printed): \_\_\_\_\_

Date: \_\_\_\_\_

Medical Provider License # and State: \_\_\_\_\_

Medical Provider Phone Number: \_\_\_\_\_