Submit this form to:

Student Health Center
204 W. Washington Street
Lexington, VA 24450
Fax: (540) 458-8404
studenthealth@wlu.edu

Phone: (540) 458-8401

WASHINGTON AND LEE UNIVERSITY

Lexington, Virginia 24450-2116

MEDICAL DOCUMENTATION FOR SPECIAL HOUSING REQUEST

Return this form only if you are requesting special housing due to a health condition

TO BE COMPLETED BY THE STUDENT'S HEALTHCARE PROVIDER

STUDENT'S FULL NAME: _____ CLASS YEAR: _____

New Students: All first year housing is air conditioned. Our availability to accommodate other special housing requests is limited. If you believe, you have such a need you will need to have your healthcare provider complete this form and submit it to the Student Health Center for review by **May 31st**.

Returning Students: Please discuss any special housing needs with the Student Health Center by **April 15th.** Our healthcare providers can review your request and complete this form if the necessary documentation is available in your medical record. If necessary, you will be asked to schedule an appointment with the Student Health Center to assess your health status and any special housing needs.

Provider: Special housing options on campus are limited. Only those students with the greatest medical need(s) will be recommended for special housing arrangements. In order to make this determination, it is important that the medical documentation support the request and is complete.

Please note that this is not a request for disability accommodations. For students with a qualifying disability, request for disability accommodations in housing should be made according to the Accommodation Policy and Procedures for Students with Disabilities. See https://go.wlu.edu/OGC/ugDisabilityPolicy.

1. What is the medical problem, and how does it affect housing needs?

2. Describe medications, treatments or other measures that are being employed in treatment.

3. What is the specific housing need for this individual, and why is it important in treating this problem?

PLEASE ATTACH ANY PERTINENT CLINICAL DATA DOCUMENTING THE MEDICAL PROBLEM.

Provider's Signature: _____ Date: _____/_____/_____

Provider's Name (printed): _____

Provider 's Address: _____

Provider 's Phone: (_____) _____-_____ Provider's FAX: (_____) _____-_____