



Disability Access Services
P.O. Box 30001, MSC 4149
Las Cruces, NM 88003-88001
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**New Mexico State University
Disability Access Services (DAS)**

Diagnosis Verification Form for Housing Accommodations Requests

Student Name: _____ Aggie ID: _____

The above-named student has informed New Mexico State University (NMSU) that their disability/impairment prevents them from having equal access in the campus housing facilities. In order to make a determination for reasonable housing accommodations, DAS needs documentation from a licensed clinical professional or healthcare provider who is directly responsible for the treatment of the student's disability/impairment. We request receiving sufficient information in order to determine appropriate accommodation(s) in accordance with provisions of state and/or federal laws. Please complete all questions on this form and provide any documentation needed to make an accommodation determination.

Recommendations for accommodation(s) are helpful and will be given due consideration.

Provide a diagnosis of the condition or a brief description of the disability or impairment:

Condition: Permanent Temporary until _____ Severity: Mild Moderate Severe Partial remission

When did you first see the student for the condition: _____ Date of last visit: _____

Are you still the student's current provider? _____ Frequency of appointments: _____

What specific major life activities or functioning does the condition impact that requires an accommodation in campus housing?

What specific recommendations do you have for housing accommodations that should be provided due to the student's disability/impairment?

How will these recommended accommodations mitigate the barriers and impact they are experiencing due to their disability/impairment :

If you are recommending an exemption for mandatory on-campus housing, an exemption from a meal plan, or a termination of an existing housing contract, please provide clear justification how the exemption or early release of the student's housing contract is necessary as a reasonable accommodation. Please be clear as to the relationship between the disability and the request?

For what period of time do you suggest the reasonable accommodation(s) be made?

Certifying Clinician/Licensed Practitioner:

Practitioner's Signature: _____ Date: _____

Print Name/Title: _____ License number: _____

Agency Name: _____

Address: _____ Email: _____

Phone Number: _____ Fax Number: _____