AIR CONDITIONER REQUEST DUE TO A DISABILITY

Last Name:_____________________________________________________
First Name:____________________________________________________
Phone Number:_________________________________________________

Semester Requesting Air Conditioning Begin
(academic year and semester, e.g. Fall ’18)
____ Immediately (student currently living in housing)
____ Fall’____
____ Spring’____

This Air Conditioning Request Form is to be thoroughly completed and returned to Disability Services and it will be reviewed by the campus Housing Accommodation Committee. Incomplete forms will not be reviewed.

The College is required to provide reasonable accommodations for the limitations of qualified students with disabilities.

Students with disabilities who believe they will need reasonable accommodation in the form of an air conditioned room must initiate the request by completing this form. Each request is reviewed on an individualized basis and students are reminded that air conditioners/air conditioning is available as an accommodation only to students who establish a need for an air conditioner due to a physical or mental impairment that substantially limits one or more major life functions.

Students who do not have disabilities but want an air-conditioned room should go through the regular room draw process with Residence Life.

To make this determination, it is important that the medical documentation support the request and is completed before the deadlines outlined below. If the medical documentation lacks sufficient information to determine whether the student has a disability or whether the requested accommodation is necessary, Disability Services will inform the student in writing of the verification’s
Among other accommodations, many students request air conditioned rooms. Because there are limited residence halls with air conditioning, students are encouraged to submit requests as soon as possible to avoid possible delays.

**New Students:** If you believe you have such a need, you and your treating professional should submit if for review by **June 15th**.

**Returning Students:** This form should be completed and returned by **February 15**.

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This form is to be completed by a Licensed Physician or Medical Specialist:

Please respond to the following questions regarding the student named above:

1.) Please indicate when you first started seeing the above-named patient for the impairment/condition described in this form:

______________________________________________________________________________
______________________________________________________________________________

2.) Please indicate whether the student has a physical or mental impairment that substantially limits a major life activity, and if so, what the condition is, what major life activity is substantially limited by it, and how the major life activity is substantially limited by the impairment:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3.) What accommodation is needed to provide the student an equal opportunity to use and enjoy College housing? Why?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
4.) What is the severity of the condition? (i.e. are the symptoms mild, moderate, or severe; how often do the symptoms manifest (continuously, intermittently)?

___________________________________________________________________________

___________________________________________________________________________

5.) How long is this condition likely to persist?

___________________________________________________________________________

___________________________________________________________________________

The provider may also send a report that provides additional related information. The provider completing this form cannot be related to the student and must practice in the specialty area related to the condition identified.

Provider Name (Printed)___________________________________________________________________________

Signature of provider:__________________________Date:__________________________

License #:____________________________________________________________________________________

Address:_______________________________________________________________________________________

City:__________________State:__________________

Telephone #:__________________________Fax#:__________________________

The above information can be provided to The Office of Disability Services via:

- Secure fax to 814-332-2987
- Email to jmangine@allegheny.edu
- Send US mail

Allegheny College
Disability Services Box#6
520 North Main Street
Meadville, PA 16335