Northeastern University

Request for Health-Related Housing Accommodation:

Student authorization to clinician

*For students requesting an air conditioner, carpet-free room or personal furniture only. Students making other requests should see www.northeastern.edu/drc

Dear: _____ ,
(Name of Clinician)

I am requesting the following specific housing arrangement/alteration in my residence hall at Northeastern University:

☐ air conditioner ☐ carpet-free room ☐ personal furniture (mattress)

In order to be considered for this health-related specific housing arrangement, I must submit the Health-Related Housing Accommodation Form, completed by my treating clinician. The form is attached.

☐ I hereby authorize you to complete the attached form and release it to Debbi Auerbach.

☐ I also authorize you to speak with Debbi Auerbach to provide consultation concerning the requested health-related housing arrangement.

Please submit the completed form to:
Debbi Auerbach
By email: d.auerbach@northeastern.edu
Address:
Dodge Hall 20
Northeastern University
360 Huntington Avenue
Boston, MA 02115

By confidential fax: 617-373-7800

Thank you for your timely assistance with this matter.

Sincerely,

_____ _____
Student Signature Date

_____
Print Name

Housing Accommodation Request Form

**For students requesting an air conditioner, carpet-free room or personal furniture only. Students making other requests should see www.northeastern.edu/drc*

This form is to be filled out by the student's current treating clinician

1. **Patient's/Client's name**: _____

2. **Diagnosis**: _____

3. **Please provide full DSM or ICD-10 code**: _____

4. **Initial date of diagnosis**: _____ **Date of last clinical contact**: _____

5. **What is the frequency of the disorder's symptoms for this student?**
   ☐ ongoing ☐ episodic (Please indicate frequency and duration below)

6. **The extent of the impairment is**: ☐ Mild ☐ Moderate ☐ Severe

7. **Please explain why the student's health-related condition requires the housing accommodation he/she indicated on the cover sheet.**

8. **Certification**

Clinician's name: _____

Clinician's state licensure/certification #: _____

Area of specialty: _____ Clinician's phone #: _____

_____ _____

Clinician's signature Date