Office of Health Services
MacClosky Townhouse Commons
515 Loudon Road
Loudonville, NY 12211
Telephone# 518-783-2554
Fax# 518-783-2961

AIR CONDITIONER REQUEST DUE TO A DISABILITY

Name	Current Housing Assignment	
Date of Birth	SID #	Cell Phone Number

This Air Conditioner Request Form is to be thoroughly completed and returned to Health Services. Incomplete forms will not be reviewed. 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.

Deadline to submit: Requests for Fall semester are due for **RETURNING** students by **February 1st** and **NEW** students are due by **June 30th. For all Spring semester students, requests are due by December 1st.**

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. As per the American with Disabilities Act, please indicate whether the student has a physical or mental impairment that substantially limits a major life activity.

   a) What is the Physical or mental impairment?

   _____

   b) What major life activity is substantially limited by the impairment?

   _____
   _____
   _____

   c) How is the major life activity substantially limited by the impairment?

   _____
   _____
   _____

3. What diagnostic testing have you performed for the impairment and what were the results?

_____
_____
_____

4. How are the symptoms of the impairment manifested?

_____
_____
_____

5. What is the severity of the condition?

_____
_____
_____

6. How long is this condition likely to persist?

_____
_____
_____

7. Describe the symptoms related to the student's condition, if any, that cause significant impairment in one or more major life activities and which would support the student's request for the accommodation being requested:

_____
_____
_____

8. Please identify any prescription and/or over the counter medications taken to manage symptoms with frequency of the dose.

_____
_____
_____

9. Are allergy injections given? Yes _____, or No _____
   - If Yes: what type and frequency:

     _____
     _____

10. Are the symptoms: Continuous _____, Intermittent_____ or Seasonal_____?

11. Are the symptoms: Mild _____, Moderate _____, or Significant _____?

12. Is the use of an air conditioner: Desirable_____ or Essential_____ to participate in the College's residential program?

13. In your opinion, how important is it for the student's well being to have the accommodation being requested? (1 = not important, 5 = critically important).

_____

14. Please explain the rationale for your response to the previous question:

_____
_____
_____

15. What consequences, in terms of impairment-related symptomology, would in your opinion result if the College does not approve the requested accommodation?

_____
_____
_____

Signature of Provider:_____Date: _____

Address: _____

City:_____State:_____ ***Affix Office Stamp Below***

Telephone #: _____

Fax #: _____

OFFICE USE ONLY

Request Review Date _____ By: _____

Committee Review Date: _____ Decision: Approved _____ Denied _____ Pending _____

Student Notified	Date: _____	By: Portal Message _____
Community Living Notified	Date: _____	By: E-Mail _____
Facilities Notified	Date: _____	By: E-Mail _____
Accessibility Services Notified	Date: _____	By: E-Mail _____