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

WITHDRAWAL FROM HOUSING DUE TO A MEDICAL REASON

Name		
Date of Birth	SID #	Cell Phone Number

As outlined in Siena Life and the College Catalog, Siena College has a 4-year residency requirement. Your signature on the Housing License Agreement and/or your acceptance of an assigned space and room key signifies your agreement to and acceptance of all the terms of the Housing License Agreement. The Housing License Agreement requires all full time students to live in college residence facilities.

If an extraordinary and unforeseen circumstance exists and all avenues of resolution have been exhausted, a student may file a petition for release from the Housing License Agreement. Petitions will only be granted in extraordinary circumstances, as determined at the discretion of the College (e.g., roommate conflicts, finding "preferable" housing off campus, and/or not being assigned to your first choice accommodation are not valid reasons for release.)

CONDITIONS FOR REVIEW: When submitted, your request must include detailed official documentation supporting the claim, which will be reviewed according to the request. Your request will be reviewed *only* if the petition is complete and *all* required documentation is provided with the petition.

- Your completed petition will be reviewed within 10-14 business days of submission.
- Petitions submitted without documentation will be returned without review.

DOCUMENTATION: To be able to provide the most informed response, you are asked to provide a complete set of documents supporting your request. The documentation must validate that:

- The situation has arisen since the submission of your Housing License Agreement.
- The situation is beyond your control.
- You have exhausted all resources to help resolve this situation.
- The only solution to the situation is a release from the residency requirement.

For Physical Health Conditions: This Form is to Be Completed by a Licensed Physician or Medical Specialist

For Mental Health Related Conditions: This form is to Be Completed by a Licensed Psychiatrist, Psychologist, or other Licensed Mental Health Professional

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. What is the student's medical condition/diagnosis, date of onset?

_____

_____

_____

3. What is the severity of the condition?

_____

_____

_____

4. How long is this condition likely to persist?

_____

_____

_____

5. 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:

_____

_____

_____

6. Please describe any elements of the student's current treatment plan (including any medications or special diet) that would implicate issues related to the College's residential program:

_____

_____

_____

_____

7. Based on the student's current medical condition, please indicate why the student's condition prevents him/her from living in a college residence facility:

_____

_____

_____

8. Is the condition a physical or mental impairment that substantially limits a major life activity?
___ Yes ___ No

9. If "yes", please identify the physical or mental impairment, what major life activity is substantially limited by it, and how the major life activity is substantially limited:

_____

_____

_____

10. 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). _____

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

_____
_____
_____

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

_____
_____
_____

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.

Signature of Provider:_____Date: _____

Address: _____

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

Telephone #: _____

Fax #: _____

OFFICE USE ONLY

Request Reviewed: Date _____ Approved_____Denied_____

By _____

Student Notified: Date_____ By: E-Mail_____Letter_____

Community Living Notified: Date_____ By: E-Mail_____Letter_____

Other:_____