RELEASE OF INFORMATION
FOR VERIFICATION HOUSING ACCOMMODATION

The student completes the following:

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

☐ Please return paperwork to client/student.

☐ Please return the completed information to the campus checked below:

☐ Florida Atlantic University
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University
Student Accessibility Services
3200 College Avenue, LA 131
Davie, FL 33314
tel: 954.236.1222 fax: 954.236.1123

☐ Florida Atlantic University
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

Florida Atlantic University
Student Accessibility Services
DOCUMENTATION FOR A HOUSING ACCOMMODATION

Student Name: _____

1. Do you have a professional relationship with that patient/client involving the provision of health care or disability-related services? YES____ NO____

2. Confirmation of a disability: YES____ NO____

3. Housing accommodation requested: _____
_____
_____

4. Relationship between student's disability and the need for the requested accommodation: _____
_____
_____
_____

5. Is there an alternative if the recommended housing accommodation is not available? If so, please indicate.
_____
_____

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SIGNATURE OF PHYSICIAN/CLINICIAN: _____
PRINT NAME: _____ DATE: _____
CREDENTIALS_____ SPECIALTY_____
LICENSE/CERT. #_____ STATE_____

Please attach your business card.