



**Marietta College**

ACADEMIC RESOURCE CENTER

## **Housing Accommodation Application for New Students**

This form is to be completed by any incoming Marietta College student seeking housing accommodations due to a documented disability or medical condition (other than the request for an air conditioner). To assist in the full and fair evaluation of such requests, the student seeking accommodations is responsible for completing the following process:

- 1) This *Housing Accommodation Application* must be completed in full and returned to the Accessibility Specialist in the Academic Resource Center.
- 2) Once the application has been submitted in full, the Accessibility Specialist will contact the student by phone or email to discuss the application and ask any necessary questions for clarification. If possible, the best scenario would be to have an in-person meeting with the student to discuss the accommodations.
- 3) **IF** the housing accommodation is approved, the student will be contacted by the Marietta College Housing Officer to confirm the assigned room and accommodations.

Please direct any questions and return completed forms to:

Kristin English

Accessibility Specialist

Academic Resource Center

Marietta College

215 Fifth Street

Marietta, OH 45750

740-376-4467 (phone)/ 740- 376- 4406 (fax)

Email: [thomask@marietta.edu](mailto:thomask@marietta.edu)

**Marietta College Housing Accommodation Application**

**Part I. To Be Completed by the Student**

Student Name: \_\_\_\_\_ MC ID# \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Date submitted: \_\_\_\_\_ for Term \_\_\_\_\_.

Description of housing accommodation being requested:

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Reason housing accommodation is needed:

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I, \_\_\_\_\_, certify that the information presented on this application is true.

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Student Signature

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Date

**CONTINUE TO PART II WHICH MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER IN ORDER FOR THE APPLICATION TO BE ACCEPTED**

## Marietta College Housing Accommodation Application

### Part II. To Be Completed by Health Care Provider

Student Name: \_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Practitioner should provide the following:

- 1) Verification that you have been actively treating the individual making the request
- 2) Verification that the individual has a qualifying medical condition or disability that limits a major life activity
- 3) Recommended accommodation(s) and duration of accommodation
- 4) Explanation of how the reasonable accommodation(s) will assist the student.

This information should be provided on your professional office letterhead and be included with this sheet.

You may return the documents to the student to be submitted to our office or you can send them to our office directly through our confidential Fax at 740.376.4406 or they may be sent through standard mail.

To send documentation or for any questions please contact:

Kristin English

Accessibility Specialist

Academic Resource Center

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