As part of our mission to foster diverse and inclusive learning and living environments, Bates College is committed to supporting students with documented disabilities. As a residential community, Bates prioritizes the residential experience, including dining, as an essential part of our institutional commitment to educating the whole person.

All students admitted to Bates enjoy full access to its programs and services, including residence life and dining. In accordance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act, Bates has established procedures to ensure students with documented disabilities receive reasonable accommodations to meet their needs.

Students who encounter a disability related barrier to their housing or dining experience should submit this accommodation request form along with any supporting documentation. Please visit the Accessible Education and Student Support website for guidelines on disability documentation.

Note: A standard housing assignment is a two or three person sleeping room with bathroom facilities located on the same floor, but not in the room. Requests for particular housing assignments based on a student’s preference, rather than need, for a particular type of living environment, such as a certain type of room or location or desire for a quiet place to study will not be honored. Single rooms represent a small portion of available housing options and are granted as accommodations only in rare circumstances. Such requests will be reviewed on a case-by-case basis.

FOR STUDENTS: This form should be completed by your health care professional and returned directly to:
Office of Accessible Education and Student Support
Bates College
48 Campus Ave, Ladd Library G33
Lewiston, ME 04240
Email: accessibility@bates.edu / Fax: 207-786-8290 / Phone: 207-786-6222

TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL:

This form is to be completed for students requesting a housing and/or dining accommodation from Bates College based on an asserted disability. The Americans with Disabilities Act defines an individual with a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.” Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of major bodily functions.

Student Name: ____________________________________________  Date: _________________________

Name and professional credentials of the provider making the recommendation:

________________________________________________________________________________________

Based on the above definition, does the individual have a disability?  □ YES □ NO

If yes, please indicate the disability/disabilities: ______________________________________________________________________

Please provide the code(s) for the disability/disabilities (if applicable): ________________________________

Code source(s): □ DSM-V  □ DSM-IV-TR □ ICD-9 □ ICD-10

Date of diagnosis: _________ Made by you? □ YES □ NO If not, by whom? __________________________

Number of consultations in past 3 years: _______ Date of most recent evaluation: ____________________
Length of time under your care: ___________________ Is student currently under your care? □ YES □ NO

Medical/therapeutic equipment needed: __________________________________________________________

Prescribed medications (include dosage): __________________________________________________________

Please check which of the following major life activities is substantially limited by the disability:

__ Seeing  __ Hearing  __ Eating  __ Sleeping  __ Walking  __ Standing  __ Lifting  __ Bending  __ Speaking  __ Breathing  __ Learning  __ Reading  __ Concentrating  __ Thinking  __ Communicating  __ Working  __ Operation of bodily functions

Other(s): _________________________________________________________________

Please describe in detail how the disability/disabilities interfere(s) with any major life activity that would be encountered in a residential environment or affects their dining experience (please use additional space if needed, attachments are welcome):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please discuss the status (static or changing) of the student's condition:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

If the effect of a disability includes recurring symptoms, please indicate their approximate frequency:

□ Periodic w/ ____ annual reported occurrences  □ ___ times per week

□ Seasonal w/ ____ annual reported occurrences  □ Most days

□ Every ___ months  □ Daily

□ ___ times per month

Please describe and provide your rationale for any modifications you recommend to accommodate the student's disability. Please explain how your recommendation(s) would remove any barriers to access or participation in the residential environment or dining experience (use additional space as needed):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
What are possible alternatives if meeting your primary recommendation(s) is not possible?

Accommodations for this disability are recommended:

__ for the next 3-5 months
__ for the next 6-9 months
__ for the next year
__ for the duration of time in college
__ duration unknown
__ other: _________________________________

Would this student be at greater risk in a fire than a student without a disability? If yes, please explain:

__________________________________________________________________________________________

__________________________________________________________________________________________

I have attached supporting documentation for this diagnosis □ YES □ NO

<table>
<thead>
<tr>
<th>Health Care Professional’s Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Address:</td>
</tr>
<tr>
<td>Email: _______________________________</td>
</tr>
<tr>
<td>Signature: ___________________________</td>
</tr>
</tbody>
</table>

My signature confirms that I am or have been this student’s treating health care professional and that I am not a relative of the student.