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: 207-786-8397 / 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.

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
- Lifting
- Concentrating

- Hearing
- Bending
- Thinking

- Eating
- Speaking
- Communicating

- Sleeping
- Breathing
- Working

- Walking
- Learning
- Operation of bodily functions

- Standing
- Reading

Other(s): _______________________________  

If the student has dietary restrictions, please select from the following:

- Gluten
- Dairy
- Soy

- Nut
- Other

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
- [ ] Seasonal w/ [___] annual reported occurrences
- [ ] Every [___] months
- [ ] ___ times per month
- [ ] ___ times per week
- [ ] Most days
- [ ] Daily

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
### Health Care Professional’s Contact Information

<table>
<thead>
<tr>
<th>Office Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email: ____________________________ Phone: ____________________________</td>
</tr>
<tr>
<td>Signature: ________________________ Date: ____________________________</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.*