All High Point University (HPU) students requesting disability-related accommodations in relation to housing must register with the HPU Office of Accessibility Resources and Services and provide up-to-date, appropriate, and objective documentation that clearly substantiates a significant functional impairment. A significant functional impairment is a limitation or inability to perform one or more major life activities without an accommodation.

Housing accommodations will be based on documentation submitted to the Office of Accessibility Resources and Services.

To receive housing accommodations at High Point University, students must:

1. Register with the Office of Accessibility Resources and Services (OARS) at [http://www.highpoint.edu/oars/](http://www.highpoint.edu/oars/) using the COMPASS Portal.

2. Submit a completed OARS Request for Medical Documentation for Accessible Housing by a licensed professional who is credentialed in the area related to the diagnosed condition for which the accommodation is being requested.

3. Write and submit a Personal Statement that includes a rationale for your housing accommodation and how this accommodation will meet your need(s) for accommodations and enrich your experience at High Point University.

4. Meet with an Accessibility Specialist to discuss your request. If you are an incoming first year student, you can contact an Accessibility Specialist by calling 336-841-9026.

The following documentation in itself is not sufficient to authorize a housing accommodation, but may be provided to assist in determination of reasonable academic accommodations.

- Individualized Education Plan (IEP)
- 504 Plan
- Psychological Test results

Please submit all documentation to High Point University’s Office of Accessibility Resources and Services by email oars@highpoint.edu.
MEDICAL DOCUMENTATION REQUEST FOR ACCESSIBLE HOUSING

Re: _______________________________  DOB: _______________________________

The forenamed student has requested accommodations from the Office of Accessibility Resources and Services at High Point University on the basis of having a disability. This student reports being diagnosed with a physical or mental impairment which substantially limits one or more major life activities. This may include but is not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Please complete all sections of this form and return to: Office of Accessibility Resources and Services, One University Parkway, High Point, NC 27268, FAX 336-888-6324, or oars@highpoint.edu. This verification form must be completed and returned before accommodations can be provided.

To be completed by a licensed professional:

Provider: _______________________________ Title: _______________________________

Address: ________________________________________________________________

Phone: ___________________ Email: ____________________________________________

License Number: _______________ Office Name: _______________________________

1. What is the student’s diagnosis? What is the original date of the diagnosis?

________________________________________________________________________

________________________________________________________________________

2. Is the student/patient currently under your care? ☐ Yes ☐ No

   a. If so, duration of care? ________________________________________________

   b. Date of most recent contact? __________________________________________
3. What Major life activities are limited due to this diagnosis?

___ breathing  ___ bladder  ___ bowel  ___ circulatory  ___ concentration  ___ cognition
___ dexterity  ___ digestive  ___ eating  ___ endocrine  ___ hearing
___ immune system functions  ___ memory  ___ neurological  ___ normal cell growth
___ performing manual tasks  ___ respiratory  ___ seeing  ___ self-care  ___ sleeping
___ talking  ___ walking  ___ working  ___ other

Please explain how the student’s major life activities limited by the student’s diagnosis.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4. Is the impact of the condition life threatening if the request is not met? ________________

In what way? __________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

5. Is the request an integral component of a treatment plan? ____________________________

How does the accommodation meet the needs and intent of the student’s treatment plan?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

6. Describe how this condition affects the student’s life functioning, specifically in relation to the student’s housing experience (e.g. duration, frequency, intensity of condition).

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
7. Does the condition impact the student’s ability to utilize the campus shuttle service? ________
In what way? ____________________________________________________________________________

8. What specific recommendations for accommodations do you have regarding housing assignment? Indicate if any recommendations are medically necessary. (Suitemates are not roommates but may share a common area with the student such as a living room and/or kitchen).
   _____Single Room w/ Suitemates    _____Single Room w/o Suitemates    _____Ground Floor
   _____Kitchen Access        _____Semi-private Bathroom        _____Other (please describe)

   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

9. Explain how the recommended accommodations decrease the impact of the student’s functional limitations associated with their life on campus at High Point University.
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

10. Please include any other information that might be helpful in working with this student.
    ____________________________________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________

Licensed Professional’s Signature ___________________________ Date Completed ______________

Professional’s Printed Name ___________________________ Date Licensed ______________