HOUSING AND RESIDENCE LIFE

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VERIFICATION OF DISABILITY/CHRONIC HEALTH CONDITION

For the Purpose of Freshman Live-In Rule Waiver Consideration (FLIR)

As supported by research, living in the residence halls on campus is proven to increase the likelihood that students will continue their postsecondary education, receive a higher GPA, and find a supportive community at Washington State University (WSU). Therefore, the Washington Administrative Code (WAC) requires all single undergraduate freshmen under 20 years of age to live in organized living groups which are officially recognized by the university (residence halls, fraternities, and sororities) for one academic year.

The student named below has applied for consideration to be waived from WSU's Freshman Live-In Rule (FLIR). In order to determine eligibility, we require documentation of the student's disabling health condition as it relates to living in the residence halls. This documentation could address permanent disabilities, diseases or illnesses, other health problems that may be short- or long-lasting, injuries, and mental or emotional conditions.

Under the Americans with Disabilities Act (as amended) and Section 504 of the Rehabilitation Act, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under these laws, documentation must indicate "a physical or mental impairment that substantially limits one or more major life activities," including the ability to function in a postsecondary academic environment. A diagnosis of a disorder, in and of itself, does not automatically qualify an individual for eligibility to be waived from the housing requirements. **Therefore, documentation must provide information about how the patient's functioning is limited, and substantiate their request for a FLIR waiver. ALL QUESTIONS MUST BE ANSWERED. INCOMPLETE FORMS WILL NOT BE CONSIDERED.**

SECTION 1 - To be completed by STUDENT

Name (First and Last)

ID Number

Date of Birth (MM/DD/YYYY)

Phone Number

Email Address

Current/Permanent Address

My **signature** authorizes my medical provider to release the following information to WSU:

SECTION 2 - To be completed by LICENSED HEALTHCARE/MENTAL HEALTH PROVIDER

General Description of Condition:

Prognosis/Anticipated Duration:

- ☐ Permanent/Chronic
- ☐ Intermittent
- ☐ Temporary, expected to last (days/weeks/months):

Date of Diagnosis (MM/DD/YYYY)

Date when patient was first seen for this condition:

Date when patient was last seen for this condition:

Please continue to the next page.

SECTION 3 - To be completed by QUALIFIED PROFESSIONAL

The following questions ask about difficulties due to health conditions experienced by the person about whom you are responding in your role as healthcare provider.

during the past 30 days, how much difficulty did your patient have with:

	None	Mild	Moderate	Severe	Extreme or Cannot Do	Unknown to Physician
Dealing with people he or she does not know?	○	○	○	○	○	○
Making new friends?	○	○	○	○	○	○
Personal hygiene?	○	○	○	○	○	○
Eating?	○	○	○	○	○	○
Sleeping?	○	○	○	○	○	○
Breathing?	○	○	○	○	○	○
Staying by himself or herself for a few days?	○	○	○	○	○	○
Starting and finishing his or her day-to-day personal/school responsibilities?	○	○	○	○	○	○
Closed spaces?	○	○	○	○	○	○
Noise?	○	○	○	○	○	○
Motivation?	○	○	○	○	○	○
Chemical sensitivity?	○	○	○	○	○	○

Please describe **how the patient's functioning is substantially limited** by his/her medical condition/disability. Please explain how these limitations are caused by the diagnosed condition (including medication side effects), and the **major life activities** affected for which **living on campus would create a negative impact on the patient's health**. Major life activities include, but are not limited to: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Specify whether you recommend this individual to live on or off campus. If off-campus living is recommended, please explain **how the functional limitations resulting from their health condition are alleviated by living off campus as opposed to living on campus**:

Please continue to the next page.

What accommodations, if any, would successfully address the limitations of the student's medical condition, and thereby allow the student to remain in the residential setting? (Examples include, but are not limited to: single room, private bathroom, central air conditioning, etc.)

SECTION 4 - To be completed by QUALIFIED PROFESSIONAL

Please provide your name, title, and professional credentials - including license, certification, or area of specialization, employment, and the state/province and country in which you practice. ***By signing below, you are certifying that you are not a family member of the student/patient named above, the clinical information provided was based on your current and comprehensive evaluation, and you have the professional training, background, and qualifications to provide the foregoing information:***

Printed Name | Signature | Date

Professional Title | License #

Board Certification/Area of Specialization

Name of Organization | Position Title

Street Address | City | State | Zip Code

Phone # | Fax # | Email Address

This is the end of the form.

TO BE COMPLETED BY UNIVERSITY STAFF ONLY

Recommendation to Housing and Residence Life:

- ◯ Approve
- ◯ Do Not Approve
- ◯ Provide Accommodations: