

**MEDICAL HOUSING REQUEST FORM**

**Single Room**

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Instructions for completion of the Medical Single Request Form

* Student fills out the request with a representative of the Medical, Academic, & Psychiatric (MAP) Committee (Student Health Services, Center for Accommodative Services, or Student Counseling Center) and receives Medical Housing Procedures checklist.
* Student submits a letter detailing reasons for the request with the form
* Documentation from an outside provider must follow the Medical Housing Request form and letter of request. The documentation must be on the Request for Documentation forms provided by the Counseling and Health Centers and should specify that the student has a medical/psychological condition that would warrant a medical housing accommodation for the specified semester/year.

Paul Smith’s College

**MEDICAL WITHDRAWAL REQUEST FORM**

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Section I: To be completed by the student

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**Conditions specific to Medical Housing:**

It is the College’s intention to support students in a successful experience at Paul Smith’s College when disability indicates that housing accommodations may be helpful. To this end:

* All requests will be reviewed by the MAP Committee once application paperwork is complete, and must be approved before a recommendation is made to Residence Life regarding housing.
* Requests can only be approved to the extent that appropriate space is available.
* New fall semester entrants must make the request and follow the procedures by July 15. New January entrants must make the request and follow the procedures by December 15th. Returning students must make the request and follow the procedures by the second week of December for the spring semester. For the Summer and Fall semester returning students must make the request, with documentation, by March 15

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Procedure to request medical housing accommodations: (to be reviewed and checked by the student please initial each stipulation)

* I am requesting a medical single. I understand there may be specific conditions applied and will discuss them with my support person at the Center for Accommodative Services, or Counseling, or Health Center if I receive the accommodation.
* I understand I must complete a PSC Housing Application form or go through Lottery.
* I understand I must submit a letter to Chair of the MAP Committee requesting this accommodation and explaining why it is appropriate, as well as current documentation along with the letter; I will sign releases as necessary.
* I understand I must contact the MAP Committee Chair [accommodativeservices@paulsmiths.edu](mailto:accommodativeservices@paulsmiths.edu) to provide specific information regarding my disability and needs
* All requests will be reviewed by the MAP Committee once application paperwork is complete, and must be approved before a recommendation is made to Residence Life regarding housing.
* I understand that it is recommended that I check with the appropriate offices and agencies (financial aid, residential life, Student Accounts, scholarships, etc.) to inquire about potential implications of medical housing.
* I understand that in order to facilitate my request the MAP Committee may need to discuss my housing with Residence Life. This permission is granted for the duration of time that I am requesting/receiving medical housing at Paul Smith’s College



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Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Request for Semester: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department:\_\_\_\_\_\_\_\_\_\_\_\_\_

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Section II: To be completed by the student

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and accepted the stipulations and conditions for medical housing accommodations outlined on the previous pages of the medical housing form. I understand that in order to facilitate my housing, the MAP Committee may need to discuss certain aspects of my plan with Residence Life. This permission is granted for the duration of time I am granted medical housing accommodations by the College.

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Section III: Optional release of information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the MAP Committee at Paul Smith’s College to exchange information with my parent or guardian regarding my medical housing at Paul Smith’s College. This permission is granted for the duration of time I am requesting/receiving medical housing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Parent(s) or guardian(s).

This authorization is for purposes of coordination of my housing. Any further discourse, copying, distribution, or use is prohibited. I understand that I have the right to cancel in writing my permission to release information at any time, except to the extent that it has already been acted upon.

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For more information, contact the relevant office for your needs:

Vanessa Case, M.S. Ed., MAP Chair   
Coordinator, Center for Accommodative Services

Phone: (518) 327-6415 Fax (518) 327 - 6369

Abigail Fontaine, RN

Director, Student Health Services

Phone: (518) 327-6349 Fax (518) 327-6309

Amy Belair, LMHC

Director, Student Counseling Services

Phone: (518) 327-6225 Fax: (518) 327-6026