New Mexico State University
Student Accessibility Services
P.O. Box 30001, MSC 4149
Las Cruces, New Mexico 88003-8001
(575) 646-6840; Fax (575) 646-5222

Verification Form for Housing Accommodations

Student's Name:_____ **Aggie ID:** _____

I authorize the New Mexico State University Student Accessibility Services Office to receive information from my provider (name)_____. I also authorize my provider to discuss my condition(s) with the appropriate and qualified New Mexico State University personnel on an as needed basis.

Student Signature:_____ Date:_____

In order to determine reasonable accommodations for housing, the New Mexico State University requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider. *The provider completing this form cannot be a relative of the student.* If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).

1) Date of Initial Contact with Student: _____
2) Date of Last Office Visit with Student: _____
3) ***Diagnosis:*** Please list all relevant diagnoses. If applicable, please list all DSM-5 or ICD Diagnoses (text and code):

_____

_____

4) Approximate onset of diagnosis: _____/_____ _____

Severity of symptoms
- o mild
- o moderate
- o severe

Prognosis of disorder:
- o mild
- o moderate
- o severe

5) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

_____

_____

_____

_____

6) Please state the specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the change(s) to the housing environment you recommend are necessary.

_____

_____

_____

_____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to the SAS office at the address shown at the end of this document.

All documentation submitted to SAS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:_____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Phone:_____ Fax:_____

Please return this form to:

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Student Accessibility Services
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Las Cruces, NM 88003-88001
Phone: (575) 646-6840
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Attach Provider Business Card Here