

Medical Request - Use of an Air Conditioner

Accommodative Services accommodations@union.edu

This form must be completed in full and submitted for review to the Special Housing Committee at accommodations@union.edu. Student completes this section: Anticipated Year of Graduation _____ _____ Union I.D. _____ First Name Last Name Applicant's Signature _____ Date Medical provider completes this section: The submitting medical provider must be one of the following: Primary Care provider, Allergist, Pulmonologist, or Ear, Nose, and Throat (ENT) provider. Your patient has requested the use of an air conditioner in their College housing location. Union College will do its best to accommodate individuals who have a diagnosed medical condition that warrants the need for an air conditioner. This will be determined on a case-by-case basis. Please provide as much detail as possible so we can have a better understanding of your patient's condition. Feel free to use additional pages if necessary. 1. What is the student's diagnosis that warrants the use of an air conditioner? 2. How will the use of an air conditioner mitigate symptoms?

3. Is the condition intermittent or seasonal in nature? When and how often is your patient

affected?



Medical Request - Use of an Air Conditioner

Accommodative Services accommodations@union.edu

4. What, if any, medication is frequency)?	prescribed to alleviate symptor	ns (include name, dosage, and
5. Can an air purifier or fan be	e substituted for an air condition	ner? If not, please explain.
Medical Provider Name (please		ial Provider/Office stamp (below):
Medical Provider's Specialty		
Medical Provider's Office Phone	e #	
Medical Provider Signature Date		
OFFICE USE ONLY: Date Received _ Reviewed by Notes	Bldg/Room Assign Date of Decision	
	Res Ed Notified Date:	Facilities Notified Date: