UNIVERSITY OF LOUISVILLE.
UNIVERSITY HOUSING

Request for Cancellation Fee Appeal

Medical Documentation Appeals Form

From: ____

Student Name and Student ID #

To: ____

Healthcare Provider Name

I understand that this is a request form and is not a guarantee of an approval of my appeal. I understand that appeals are reviewed by the Appeals Committee within 21 business days of submission of proper documentation. Failure to provide proper documentation will result in closure of my appeal.

____

Student Signature

The remainder of this form is to be filled out in its entirety by the health care professional responsible for the above patient. The patient is not to fill out the below section. *ALL INFORMATION MUST BE LEGIBLE*

Please answer and return the following questionnaire to your patient. ***The student is requesting to be released from their legal, binding license agreement. This form should be filled out if you feel that University Housing would not be able to accommodate the student on campus, even though services can be provided for any accommodation.*** The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

Name of Patient for whom you are completing this questionnaire: ______________________________

Diagnosis: ____

Date first diagnosed: ______________________ Date last seen by the provider: ______________________

Severity of Disability: ______________________

1. Does this resident have a disability – i.e, a physical or mental impairment that substantially limits one or more major life activities?

   Yes No

   a. If yes, please state the type of impairment and what major life activities are the subject of the disability (i.e., the current impact and functional limitations resulting from the disability).

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2. University Housing can provide a wide range of accommodations. Is there a reason why the provider believes that this cannot be met?

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   a. Please explain in detail why the suggested accommodation cannot be met within University Housing.

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3. Any additional information of Statement that may assist the University to understand the basis for your professional opinion regarding this accommodation request.

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By signing below, you as the Healthcare Provider are confirming that in prescribing accommodation for the resident you have agreed that everything you have written above is true.

Please attach a professional business card of the medical professional completing this questionnaire

____
Signature & Title

____
License Number & State of License

____
Date

Printed Name and Address:

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