



HOUSING & DINING SPECIAL REQUEST FOR MEDICAL REASONS

Student Information – Please Read Carefully

Health Services
DeKalb, Illinois 60115-2828
815-753-1316
healthservices@niu.edu
www.niu.edu/healthservices

If you are a student assigned to an NIU residence hall, special arrangements for Housing and/or Dining may be requested. Medical information must be submitted by a licensed healthcare provider confirming the presence of a medical condition that requires a special housing and/or dining arrangement.

1. CONTACT 815-753-1525 NIU HOUSING & DINING, NEPTUNE HALL EAST TO REQUEST CHANGE/S IN YOUR HOUSING ARRANGEMENT OR TO BE RELEASED FROM ALL OR PART OF YOUR HOUSING & DINING CONTRACT.
2. **FOR A MEDICAL CONDITION WHICH REQUIRES A SPECIAL DIET, YOU MUST FIRST CONSULT RESIDENTIAL DINING SERVICES (815-753-9556 OR RESNUTRITION@NIU.EDU). IF THEY ARE ABLE TO ACCOMMODATE YOUR DIETARY NEEDS, IT IS **NOT NECESSARY** TO COMPLETE A MEDICAL REQUEST FORM FOR HEALTH SERVICES.**
3. If review of your health information is indicated, complete the *Student Application and Authorization – Special Housing & Dining Special Request* (page 2). Please have a witness (over 18 years old) sign this form as well. Submit the completed form to NIU Health Services Admin Office, Rm 422. This will permit NIU Health Services to communicate with Housing and Dining regarding the status of the medical request and recommendations. **If your request is supported, you will need to meet with the Coordinator of Residential Facilities to provide them with necessary information needed to care for you in case of an emergency.**
4. A licensed healthcare physician / provider must complete the *Licensed Provider Medical Documentation Form* (page 3). This form states the medical condition and requirements for the need of special housing and/or dining accommodations. The original, signed documents must be received by NIU Health Services before a medical review begins. Please **DO NOT** fax information to Health Services. This document or information from it will not be disclosed to anyone outside of Health Services without authorization for *Release of Information* signed by you.
5. The Health Services administrative physician will review the medical information submitted by a medical provider/s. Medical review will be completed in approximately 5 to 7 working days after medical information is received.
6. Housing & Dining Services will be notified as to whether your documentation Supports or Does Not Support your request. A copy of the memo will be mailed to you (the student) as well. **THE HOUSING & DINING OFFICE WILL MAKE THE FINAL DECISION CONCERNING CONTRACT CHANGES.**
7. If the medical information provided from your physician / provider is not sufficient, Health Services will notify you of this determination. You may submit additional, new medical information for the administrative physician to review.

If you have questions, please contact H.S. Administration Office: 815-753-1316, Mon – Fri, 8 AM – 4:30 PM.

H&D Req 03/16



Northern Illinois University

Division of Student Affairs & Enrollment Management

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HOUSING AND/OR DINING SPECIAL REQUEST FOR MEDICAL REASONS

STUDENT APPLICATION & AUTHORIZATION MEDICAL DOCUMENTATION

I am seeking a special housing accommodation due to medical reasons during the semester indicated below

OR

I am seeking a special dining arrangement due to medical reasons during the semester indicated below and have ALREADY MET WITH NIU RESIDENTIAL DINING (815-753-9556 OR BEEN IN CONTACT WITH THEM AT resnutrition@niu.edu)

Name Z-ID #

Address

City State Zip Code

Current daytime telephone number Date of birth

Beginning (circle one): Fall/Spring Summer Interim Year

Specific request:

- Single room
Release from residence hall contract (room and board)
Release from board contract (meal plan only)
Other

I HEREBY REQUEST AND AUTHORIZE the administrative physician or physician designee of Health Services, Northern Illinois University, DeKalb, IL 60115, to verify the presence of a medical condition that warrants a special housing and/or dining arrangement to Housing and Dining, Neptune East, NIU.

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Denial of my request for a special housing and/or dining arrangement.

I may revoke this authorization at any time by written notification to Health Services. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from the disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

Signature of applicant Date Witness Date

Print Name Print Name

Please return the completed form to the address above

Learning Today, Leading Tomorrow

Northern Illinois University is an Equal Opportunity/Affirmative Action Institution.



LICENSED PHYSICIAN / PROVIDER DOCUMENTATION
HOUSING AND/OR DINING SPECIAL REQUEST FOR MEDICAL REASONS

Student's Full Name _____ Z-ID# _____

Semester and Year of Request _____ DOB _____

Please type or print the requested information in the space provided below and return this form with original signature to the address above. DO NOT FAX.

Air-conditioning in residence halls is only available until mid-September on a limited basis.

Table with 2 columns and 3 rows. Row 1: 1. DIAGNOSIS AND CODE of the severe medical condition that requires a special housing and/or dining arrangement. Row 2: 2. For the above condition, indicate the date(s) of evaluation and f/u treatment during the past 6 months, location of evaluation and f/u treatments, and nature/purpose of each evaluation and/or treatment provided. Row 3: 3. PROVIDE THE SPECIFIC MEDICAL FINDINGS, RESTRICTIONS AND/OR OTHER OBJECTIVE DATA THAT REQUIRES SPECIAL HOUSING AND/OR DINING ARRANGEMENTS FOR THE ABOVE STUDENT.

Signature of Attending Licensed Healthcare Provider and Title

Date

Printed Name, Business Address, Telephone Number