RESIDENTIAL HOUSING and/or DINING SERVICES SPECIAL REQUEST FOR MEDICAL REASONS

Student Information – Please Read Carefully

If you are a student assigned to an NIU residence hall, special arrangements for Residential Housing and/or Dining Services 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 NIU HOUSING & RESIDENTIAL SERVICES, NEPTUNE HALL EAST 101 AT 815-753-1525 TO REQUEST CHANGE/S IN YOUR HOUSING ARRANGEMENT OR TO BE RELEASED FROM ALL OR PART OF YOUR HOUSING CONTRACT.

2. FOR A MEDICAL CONDITION WHICH REQUIRES A SPECIAL DIET, YOU MUST 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 – Residential Housing and/or Dining Services 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 & Residential Services or Campus Dining Services 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 or the Associate Director of Residential Administration 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 provider will review the medical information submitted by a medical provider/s. Medical review typically is completed in approximately 3 to 5 working days after medical information is received.

6. Housing & Residential 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 & RESIDENTIAL SERVICES 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 provider to review.

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

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RESIDENTIAL 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.

_____ 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 & Residential Services or Campus Dining Services, 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

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LICENCED PROVIDER DOCUMENTATION  
RESIDENTIAL 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.

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<tr>
<th>1. <strong>DIAGNOSIS AND CODE</strong> of the severe medical condition that requires a special housing and/or dining arrangement.</th>
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<tr>
<th>2. For the above condition, indicate the</th>
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<tr>
<td>▪ date(s) of evaluation and f/u treatment during the past 6 months,</td>
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<tr>
<td>▪ location of evaluation and f/u treatments (e.g., office, hospital OP, hospital IP, etc.); and</td>
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<td>▪ nature/ purpose of each evaluation and/or treatment provided.</td>
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<th>3. PROVIDE THE SPECIFIC MEDICAL FINDINGS, RESTRICTIONS AND/OR OTHER OBJECTIVE DATA THAT REQUIRES SPECIAL HOUSING AND/OR DINING ARRANGEMENTS FOR THE ABOVE STUDENT.</th>
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Signature of Attending Licensed Healthcare Provider and Title ____________________________ Date ____________________________

Printed Name, Business Address, Telephone Number ____________________________________________

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