



## HOUSING & DINING SPECIAL REQUEST FOR MEDICAL REASONS Student Information - Please Read Carefully

**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 with Residential Dining Services (815-753-0563). If they are able to accommodate your dietary needs, it is not necessary to complete a medical request from 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 Administration Office, Room 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 approved, you will need to meet with the Coordinator of Residential Facilities to provide him with necessary information needed to care for you in case of an emergency.
4. A licensed healthcare provider must submit the *Licensed Provider Medical Documentation Form* (page 3) to NIU Health Services. This form provides 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 in support of your request of special housing/dining accommodations for medical reasons. Medical review will be completed in approximately 5 to 7 working days after medical information is received by Health Services.
6. Housing & Dining Services will be notified of the *Recommendation* for the change/s in your contract and 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 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 NIU Health Services Administration Office: 815-753-1316 or 815-753-0859, Monday – Friday, 8 AM – 4:30 PM.





**LICENSED PROVIDER DOCUMENTATION FORM  
SPECIAL HOUSING and/or DINING 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.**

<p><b>1. Diagnosis and code of the severe medical condition that requires a special housing and/or dining arrangement.</b></p>	
<p><b>2. For the above condition, indicate the</b></p> <ul style="list-style-type: none"> <li>▪ <b>date(s) of evaluation and f/u treatment during the past 6 months,</b></li> <li>▪ <b>location of evaluation and f/u treatments (e.g., office, hospital OP, hospital IP, etc.); and</b></li> <li>▪ <b>nature/ purpose of each evaluation and/or treatment provided.</b></li> </ul>	
<p><b>3. Provide the specific medical findings, restrictions and/or other <u>objective</u> data that requires special housing and/or dining arrangements for the above student.</b></p>	

\_\_\_\_\_  
Signature of Attending Licensed Healthcare Provider and Title Date

\_\_\_\_\_  
Printed Name, Business Address, Telephone Number



COMPLETE THIS FORM ONLY IF SEEN BY AN NIU HEALTH SERVICES PRACTITIONER

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Z-ID# \_\_\_\_\_ / \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone# ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, the above named patient, authorize NIU Health Services to release my confidential health information to the Health Services Administrative Physician for the purpose of administrative review of my request for a Medical Withdrawal, Course Load Reduction or Special Housing/Dining Arrangement at Northern Illinois University.

Please list the names of the NIU Health Services Practitioners and staff authorized by this release:

\_\_\_\_\_

Please indicate information and dates to be released:

- Immunizations \_\_\_\_\_ Lab results \_\_\_\_\_
Office visit notes \_\_\_\_\_ X-ray results or film \_\_\_\_\_
Other \_\_\_\_\_

Diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease (AIDS/HIV) are NOT included in a general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require diagnosis of Mental Health, Alcohol and Substance Abuse and Infectious Disease information specifically indicated. Please indicate information and specify dates to be released and initial.
Mental Health \_\_\_\_\_ Alcohol and Substance Abuse \_\_\_\_\_ Infectious Disease \_\_\_\_\_

I understand that I have the right to inspect and/or obtain a copy, for an appropriate fee, of the information prior to disclosure. I may revoke this authorization at any time, except to the extent that action has already been taken, by submitting a written revocation to Northern Illinois University, Health Services. If I refuse to sign this authorization, my medical record/information will not be released. This authorization will be considered valid for a 90-day period (expiration date / / ) following the date of signature unless otherwise specified here \_\_\_\_\_. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not disclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without patient authorization for such disclosure.

Processed by \_\_\_\_\_ Date Processed \_\_\_\_\_