

Functional Limitations: Please indicate level of impact on major life activity:

Functional Area	Substantial	Moderate	Mild	None	Don't Know
Communicating					
Hearing					
Seeing					
Mobility (walking, climbing, stairs, etc.)					
Sleeping					
Caring for self					
Interacting with others					
Other					

CERTIFICATION OF THE DISABILITY AND NEED FOR ACCESSIBLE HOUSING ACCOMMODATIONS.

The following is to be completed by the medical professional certifying the disability and need for the accommodations.

 First Name Last

 Practice/Place of Employment () _____
 Office Number

 Address of Employer _____
 Email

 City State Zipcode _____
 Date

 Signature

Please use agency stamp or
 attach your business card here.

Please return the completed, signed document to the SUNY New Paltz Housing Accommodation committee by emailing the form to:
DRC-housing@newpaltz.edu