If you are a student assigned to an NIU residence hall, special arrangements for Residential Housing may be requested.

If you need a special request for housing:
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.

If you need a special request for dining which requires a special diet:
YOU MUST CONSULT RESIDENTIAL DINING SERVICES (815-753-9534 OR RESNUTRITION@NIU.EDU ). IF THEY ARE ABLE TO ACCOMMODATE YOUR DIETARY NEEDS, IT IS NOT NECESSARY TO COMPLETE A MEDICAL REQUEST FORM.

If review of your health information is required:
Complete the Student Application and Authorization – Residential Housing (page 2). As you complete this paperwork, please keep the following in mind:

1. A licensed attending physician, Advanced Practice Provider (APN) or Certified Physician’s Assistant (PAC) must fully complete and sign the Licensed Provider Medical Documentation Form (page 3).

2. The original, signed documents must be received in its entirety by NIU Medical Records, Immunization, and Compliance Office before a medical review begins. Submit the completed, original form to this office in Room 209 of the Health Services Building. Please DO NOT fax/email information to us.

3. This document or information form will not be disclosed to anyone outside of our department without authorization for Release of Information signed by you.

5. We will review your submitted information. This review is typically completed in approximately 3 to 5 working days after the fully completed and appropriately signed 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, our office 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 us at: 815-753-9578, Mon – Fri, 8 AM – 4:30 PM.
RESIDENTIAL HOUSING SPECIAL REQUEST FOR MEDICAL REASONS
STUDENT APPLICATION and AUTHORIZATION
MEDICAL DOCUMENTATION

This form is to be submitted if you are seeking a special housing accommodation due to medical reasons during the semester indicated below.

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) ___
___ Other: __________________________________________________________

I HEREBY REQUEST AND AUTHORIZE Northern Illinois University, Immunization Compliance and Records Office, DeKalb, IL 60115, to verify the presence of a medical condition that warrants a special housing arrangement with Housing & Residential Services at 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 Northern Illinois University, Immunization Compliance and Records Office. 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:___________________________________________
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.

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<td>1. DIAGNOSIS AND ICD – 10 CODE of the severe medical condition that requires a special housing and/or dining arrangement.</td>
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<td>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 (e.g., office, hospital OP, hospital IP, etc.); Nature/ purpose of each evaluation and/or treatment provided; Date of initial onset</td>
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<td>3. PROVIDE THE SPECIFIC MEDICAL FINDINGS, RESTRICTIONS AND/OR OTHER OBJECTIVE DATA THAT REQUIRES SPECIAL HOUSING ARRANGEMENTS FOR THE ABOVE STUDENT.</td>
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Signature of Attending Physician, Advanced Practice Nurse or Physicians Assistant - Certified

Printed Name, Business Address, Telephone Number

Date