



Health Needs Request

Student Name: (Print) _____ LUID#: L _____

Classification: ☐ Continuing Residential Student I am a (circle): FR SO JR SR
☐ New Residential Student
☐ Readmit Student

Date to Initiate Accommodation (circle): Spring 2026 (January) Fall 2026 (August)

Longwood E-mail: _____@live.longwood.edu Telephone: (_____) _____

Enrolled residential students that have a health condition or a medical treatment plan which requires special consideration for a **main campus assignment** should complete this request form. Health needs must be submitted annually in order to be considered prior to the residence hall assignment process. Submitting a written request does not automatically guarantee that accommodations will be available.

The following deadlines will be enforced:	<i>(Late requests will not be accepted.)</i>
New Spring 2026 residents	December 1 before 5:00pm
Returning Fall 2026 residents	February 13 before 5:00pm
New Fall 2026 residents	June 5 before 5:00pm

Directions: **Section I** should be completed by the current treating physician/clinician of the student.
 Section II should be completed by the enrolled student.

SECTION I – Completed by Physician/Clinician

1. Diagnosis of health need(s)
2. Specific limitations requiring special housing
3. Current treatment that has an impact on housing placement.
4. The health need above is:
 - ☐ Permanent/Chronic
 - ☐ Long term/6-12 months
 - ☐ Short term/Temporary, 6 months or less (expected duration: _____)

5. How is the requested special housing an integral component of a treatment plan for the condition in question?

I, the undersigned, certify that this student is currently under my care.

Physician/Clinician's Signature

Date

Name (please print) and title

Agency, Address, Telephone

SECTION II – Completed by Student

1. What health need request are you making for your housing assignment for the approaching academic year?

Under the Longwood University Honor Code, I pledge that this provided information is complete and accurate.

Student Signature

Date

Return completed form to:

Residential and Commuter Life
c/o Associate Director for Residential Operations
201 High Street
Farmville, VA 23909
RCL Phone: (434.395.2080) Fax: (434.395.2704)

For Health Needs Committee Use:

Date of receipt: _____

Date of review: _____

Committee decision:

- ☐ Approve
☐ Deny

Justification:

Date of notification of RCL _____

Date of notification of student _____