

WENTWORTH INSTITUTE OF TECHNOLOGY  
**Center for Wellness and Disability Services**  
**MEDICAL ACCOMMODATION REQUEST FORM**

By completing this form, you authorize the Accommodation Committee to receive and share information from your medical provider. Documentation will be kept in a confidential file available only to members of the Accommodations Committee. The committee's decisions will be communicated to the summerFAB participant and their parent/guardian only.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

Home City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please Describe the housing accommodations that are being requested:**

**Doctor's/Medical Care Provider's Information**

Please note that all requests must be accompanied by documentation from your medical care provider. You can fax this information to: The Center for Wellness and Disability Services, Wentworth Institute of Technology, 550 Huntington Avenue, Boston, MA 02115 at 617-989-4571 or emailed to [counseling@wit.edu](mailto:counseling@wit.edu).

Provider's Information: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

For specific questions regarding the participant's housing accommodations, please contact the Center for Wellness and Disability Services at 617-989-4390 during regular office hours.