Air Conditioning Medical Exception Policy

Students are not permitted to bring or install air conditioners without documented medical reasons and approval from the Health Services Office. Any student who has a medical condition or disability that necessitates air conditioning in his/her room as part of their prescribed treatment must have a Medical Request for Air Conditioning form completed by their Primary Care Physician, Allergist, Pulmonologist, or Ear, Nose and Throat Specialist.

Once the need is documented, it will be reviewed by Health Services. If approved, Health Services will maintain a copy on file and the student will be offered air conditioned accommodations. If the need for an additional air conditioning unit is documented and approved by the University, Health Services will facilitate the installation of an air conditioning unit with the facilities staff. Air conditioner installation requests submitted by students will not be approved. Window units are the only approved type of air conditioning unit. Below is a summary of the steps to complete a request. Unauthorized air conditioner units will be removed and the student will be subject to University Disciplinary actions.

Step One: Student prints out the form and completes their portion of the form.

Step Two: Student takes form to their appropriate licensed health care professional to complete. Doctor notes, prescriptions from a physician, and other documents will not be accepted. A physician must complete the form in its entirety.

Step Three: Student delivers the completed Medical Request for Air Conditioning form to Health Services located on the first floor of Saint Peter Hall.

Step Four: After your information is reviewed, you will be notified of the status of your request. If the request is approved, you will receive additional information via your University email address.

Office of Residence Life
Mac Mahon Student Center, 5th Floor
2641 John F. Kennedy Boulevard
Jersey City, NJ
07306

Medical Request for Air Conditioning

This form must be completed in full and submitted for review to the Office of Residence Life. There are three sections to be completed: Student section, Physician section, and Health Services & Residence Life section. Incomplete forms will not be considered.

Student completes this section:

Today's Date_____ ID#:_____ Birth date:_____

First Name _____ Last Name _____

Cell Phone Number: _____

Please explain the nature of your medical condition and why you need an air conditioner._____

_____

_____

_____

I understand that this is a medical request for air conditioning based on a true medical need or disability. All requests will be reviewed on a case-by-case basis. A completed request and documentation of a need for air conditioning does not guarantee that your request will be approved. Falsification of this form will result in University Disciplinary actions.

Signature _____

AUTHORIZATION TO RECEIVE INFORMATION

I authorize Saint Peter's University to receive information from the professional who fills out the Medical Request for Air Conditioning form, and for him/her to discuss my condition(s) with Health Services Staff if necessary.

Student Name (printed): _____

Student Signature: _____ Date: _____

Physician completes this section:

The responding physician must be currently treating you. The responding physician must be one of the following: Primary Care Physician, Allergist, or Ear, Nose and Throat Physician.

Your patient (listed above) has requested the use of an air conditioner in their University Residence Hall room. Saint Peter's University has limited ability to permit air conditioners however; we do our best to accommodate individuals who have a medical condition that warrants the need for an air conditioner. Please assist us in determining how great your patient's need for use of an air conditioner is by providing the following information:

1. What is the nature of the patient's condition? Please provide as much detail as possible so we can have a better understanding of your patient's condition.

   _____

   _____

   _____

2. Is the condition intermittent or seasonal in nature? ____Yes ____No If Yes, when and how often is your patient affected?

   _____

   _____

   _____

3. What is the expected duration of the condition? ____Weeks ____Months ____Permanent ____Other

   _____

   _____

   _____

4. Is there any other relevant medical information of which we should be aware? (Attach additional sheet if necessary)

   _____

   _____

   _____

_____

Physician's Name (please print)

_____

Physician's Signature

_____

Physician's Office Phone #

Health Services & Residence Life completes this section:

OFFICE USE ONLY:

Date Received _____ Housing Assignment _____

Reviewed By _____

Approved _____ Not Approved _____

Reason _____

_____

_____