

# University of Dubuque Air Conditioner Application Form

Smeltzer-Kelly Student Health Center    Address: 1994 Grace Street    Dubuque, IA 52001  
Email: [studenthealthcenter@dbq.edu](mailto:studenthealthcenter@dbq.edu)    Phone: (563) 589-3360    Fax: (563) 589-3488

## Air Conditioners in University of Dubuque Housing

A limited amount of air conditioners will be approved based on medical provider documentation of medical necessity. Students requiring an air conditioner must submit an air conditioning request form that has been completed and signed by a medical provider. Approval of an air conditioner in the past does not guarantee the continued use of an air conditioner.

The student will provide their own air conditioner. Please contact Resident Life (563)589-3438 or [residencelife@dbq.edu](mailto:residencelife@dbq.edu) for unit size. Installation of the air conditioner unit is done only by University of Dubuque Maintenance Department. Please contact your Residence Hall Director upon arrival to complete a work order for air conditioner installation.

Before the air conditioner can be installed, the University of Dubuque Emergency and Medical Information form must be completed and the Air Conditioner Application Form must be approved.

Student will be notified via email if their request has been approved or denied.

Student Name \_\_\_\_\_ UD ID# \_\_\_\_\_ Birthdate \_\_\_\_\_

Residence Assignment where unit is requested (if known) \_\_\_\_\_ Room # \_\_\_\_\_

Semester requesting use of air conditioning \_\_\_\_\_ Sport (if applicable) \_\_\_\_\_

Please have MD, PA, or NP complete the following information (or a formal letter indicating the below can be sent):

Type of Allergy or significant medical condition:

\_\_\_\_\_

Symptoms: \_\_\_\_\_

\_\_\_\_\_

Prescriptions medication taken to alleviate condition/manage symptoms:

\_\_\_\_\_

Over-the-counter medication taken to alleviate condition/manage symptoms:

\_\_\_\_\_

Degree of Medical Necessity:    Required \_\_\_\_\_    Highly Recommended \_\_\_\_\_    Recommended \_\_\_\_\_

If AC unit is not approved, please indicate alternative resources (i.e. dehumidifier, air purifier, etc...)

\_\_\_\_\_

\*\*\*\*\*SIGN BELOW\*\*\*\*\*

Printed name of provider completing this form

Phone Number

Provider Signature

Date

Organization and Address

\*\*\*For SKSHC Use Only

\_\_\_\_\_ Approved

\_\_\_\_\_ Not Approved