MARQUETTE UNIVERSITY
Office of Residence Life Special Housing Request
(Please return form and physician's verification to: Marquette University Office of Disability Services, Special Housing Request, P.O. Box 1881, Milwaukee, WI 53201-1881)

Date: _____

Last Name: _____ First Name: _____

Email: _____ Phone No.: _____

Address: _____

_____

Describe the nature of your special housing need (including requested room type or building type):

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Please attach physician's verification to this form and list below the name, phone number, and address of your physician.

Last Name: _____ First Name: _____

Phone No.: _____

Address: _____

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