FIU | Academic & Student Affairs
FLORIDA INTERNATIONAL UNIVERSITY

Meal Plan Accommodation Request Form

Florida International University affirms the educational benefits inherent in the residential aspect of the undergraduate experience but does not require students to sign up for a meal plan membership with Dining unless living as a first-year student or first-year freshman in University Housing. However, once committed to a meal plan membership, that commitment will be for the time stated in the meal plan membership contract. Please review your meal plan membership contract carefully. Please note that accommodations are not retroactive and that all requests must be made within the semester in question.

For medical reasons, students may request to prematurely end or be exempted from the meal plan membership. To request this exemption, students must complete the Meal Plan Accommodation Request Form and comply with all inquiries from the Disability Resource Center (DRC) and/or the Meal Plan Membership Review Committee.

Instructions for Petitioning a Meal Plan Accommodation/Exemption:

1. The student requests a Meal Plan Accommodation Request Form from the FIU Campus Dining office in GC 1215 or Disability Resource Center (DRC) in GC 190. The student may also request this form via email at drc@fiu.edu. Questions can be referred to the Disability Resource Center at 305-348-3532 or drc.fiu.edu
2. Once the form is completed, it should be returned to the Disability Resource Center. The DRC's role is to facilitate this process and ensure that all the student's interests have been reviewed in an equitable fashion.
    a. **All sections of the form must be completed** prior to submitting the form to DRC.
    b. The second section must be completed by an appropriate licensed healthcare service provider with knowledge of the condition or need that is the basis of the request and the student's condition, but who is not related to the student.
    c. As needed, additional documentation may be requested supporting the statements in the Meal Plan Accommodation Request Form.
    Please Note: If the student does not respond or attend any of the meetings required to complete the exemption process, it will result in a delay in the review or denial of the request.
3. Once the Meal Plan Accommodation Request Form is satisfactorily completed, it will be reviewed by the Meal Plan Membership Review Committee.
    a. The Meal Plan Membership Review Committee is comprised of a DRC representative, the Campus Dining Registered Dietitian, the Campus Dining Executive Chef, and the Campus Dining Director of Operations. *Other University staff may be consulted when reviewing petitions for Meal Plan Accommodations.*
    b. Students may be requested to come before or provide more information to the Meal Plan Membership Review Committee If the information provided is unclear or insufficient.
4. Once a final decision is made, the DRC will email a letter to the student's University issued email account.
    a. **Please note that the decision to approve or deny a meal plan exemption request is based on Chartwells' ability to meet your dietary needs as stated on this form by your licensed healthcare provider**.
5. Please allow 3-6 weeks for processing of this request.
    a. **Appeals**: If you wish to appeal the decision based on **new medical information not previously provided**, please submit a new form to the DRC within the same semester in question.
    b. If you have any questions throughout this process, please contact the DRC so that your concerns can be addressed. Please remember this procedure is a partnership between the DRC and Chartwells Higher Ed, and inquiries may require coordination between both areas.

Section I: General Information.

(To be completed by the student)

Name (Last/First): _____ **Panther ID#:** _____

Email: _____ **Cell Phone:** (_____) _____ - _____

I am applying for a Meal Plan Accommodation for: (Semester/Year) _____

Students Must Read and Initial:

____ I understand there may be a meeting arranged between myself and the Mean Plan Membership Review Committee to determine if this application proves a medically/religiously supported condition.

____ I understand that the Meal Membership Petition Review Committee may suggest that I try alternative solutions to a Meal Plan Accommodation/Exemption.

Questions can be referred to the Disability Resource Center at 305-348-3532 or drc.fiu.edu

By signing below, I certify the information is, to the best of my ability, as accurate as possible.

Student Signature: _____ Date: _____/_____/_____

For Office Use Only

OFFICE	**DATE RECEIVED**	**DECISION**	**NOTES**
Disability Resource Center	_____/_____/_____		

Section II: MEDICAL Information.

(To be completed by the appropriate Licensed Healthcare Services Provider)

Client/Patient's Name: _____ Date: _____/_____/_____

Release of Information

I, _____, hereby authorize the exchange and release of the following confidential health or religious information below to the Mean Plan Membership Review Committee and/or the Disability Resource Center (DRC) directly for the purpose of determining my eligibility for exemption for the University's Meal Plan Membership requirement.

Student Signature: _____ Date: _____/_____/_____

The individual listed above has requested exemption from their meal membership at FIU based on a special need. To determine if the individual is eligible for this request, the University requires current comprehensive documentation to be completed by a physician or appropriate professional familiar with the student's condition and history.

1. Diagnosis and date of diagnosis.

2. List current medications, therapy, or treatments the student is currently using to control symptoms and current degree of effectiveness.

3. List symptoms of condition and severity.

Symptom of Condition	Severity of Symptom

4. List any factors in the student's diet that impact the severity of the symptom mentioned and the expected outcome.

Nutrition / Diet Factor	Symptom	Outcome

5. Please include diet/nutritional/menu accommodations that may assist the student in better controlling the symptoms mentioned above. What foods can/should be consumed?

Is there any additional comments or information that you feel the committee should be aware in terms of the outlined condition or need?

Licensed Healthcare Service Provider Signature: _____ Date: _____/_____/_____

<u>Licensed Healthcare Service Provider Information</u>

Name (Last, First, Title): _____, _____, _____

License and Specialization: _____

Address (Street, City, ST, Zip): _____, _____, ____, _____

Phone: (_____) _____ - _____ Email: _____@_____._____

Questions can be referred to the Disability Resource Center at 305-348-3532