

EMOTIONAL SUPPORT ANIMAL REQUEST VERIFICATION OF DISABILITY/CHRONIC HEALTH CONDITION

The student named below has applied for consideration to be approved for an emotional support animal in the student's place of residence. In order to determine eligibility, we require documentation of the student's disabling health condition as it relates to living in the residence halls. This documentation could address permanent disabilities, chronic diseases or illnesses, and mental or emotional conditions.

Documentation must indicate "a physical or mental impairment that substantially limits one or more major life activities," including the ability to function in a postsecondary academic environment. Documentation must provide information about how the patient's functioning is limited, and substantiate the patient's request. To facilitate a prompt review and help to avoid additional requests for documentation, please complete all questions. Failure to do so may result in delay or denial of a request.

Federal law (Fair Housing Act) allows individuals with disabilities the presence of emotional support animals in University housing. By law, an emotional support animal is defined as an animal needed for emotional support. An individual may keep an emotional support animal as an accommodation in University housing if:

1. The individual is disabled, or has a chronic medical condition that impacts a major life function.
2. The individual has presented this completed form or other documentation to the Access Center that describes the functional limitations of the individual's disability. (Under the Fair Housing Act, the request for documentation is allowed.) Documentation must be from a qualified medical provider who has an established relationship with the individual.
3. The animal is necessary to afford the individual an equal opportunity to use and enjoy WSU Housing.
4. There is an identifiable relationship between the impairment and the assistance the animal provides. This is determined through the documentation from a qualified medical provider.

NOTE: CAPS, HWS, and the Psychology Clinic (on campus) are unable to provide documentation for Emotional Support Animals unless the individual has an established relationship with one of these providers, is actively participating in counseling or treatment, and it is in the clinician's professional judgment that documentation is appropriate.

SECTION 1 - To be completed by STUDENT

Name (First and Last)

ID Number

Date of Birth (MM/DD/YYYY)

Phone Number

Email Address

Current/Permanent Address

My signature authorizes my medical provider to release the following information to WSU:

SECTION 2 - To be completed by QUALIFIED HEALTHCARE/MENTAL HEALTH PROVIDER

General Description of Condition:

Prognosis/Anticipated Duration:

Permanent/Chronic

Intermittent

Temporary, expected to last (days/ weeks/months):

Date of Diagnosis (MM/DD/YYYY)

Date when patient was last seen for this condition:

Please describe **how the patient's functioning is substantially limited** by his/her medical condition/disability. Please explain how these limitations are caused by the diagnosed condition (including medication side effects), and the **major life activities** affected for which **living on campus without the support of an animal would create a negative impact on the patient's health**. Major life activities include, but are not limited to: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Please explain how the functional limitations (i.e. symptoms) resulting from the patient's health condition would be alleviated by an emotional support animal

Are there other accommodations in addition to (or in lieu of) an ESA that would address the limitations of the student's medical condition, thereby allowing the student to live successfully in University Housing?

SECTION 3 - To be completed by QUALIFIED HEALTHCARE/MENTAL HEALTH PROVIDER

Please provide your name, title, and professional credentials - including license, certification, or area of specialization, employment, and the state/province and country in which you practice. ***By signing below, you are certifying that you are not a family member of the student/patient named above, the clinical information provided was based on your current and comprehensive evaluation, and you have the professional training, background, and qualifications to provide the foregoing information:***

Printed Name

Signature

Date

Professional Title

License #

Board Certification/Area of Specialization

Name of Organization

Position Title

Street Address

City

State

Zip Code

Phone #

Fax #

This is the end of the form.