

Emotional Support Animal Verification Form
(to be completed by licensed mental health professional only)

Student Last Name _____ First Name _____ MI _____
Program Title _____

The student named above has requested that an emotional support animal (ESA) be permitted to reside with them in AMDA Housing. In order to provide this accommodation, AMDA's Disability Resource Center requires that the student provide the below information from a mental health professional who is treating the student for a mental health impairment.

To Be Completed By Licensed Mental Health Professional Only:

Information about the Student's Disability

Does this student have a disability (physical or mental impairment that substantially limits one or more major life activities)? _____

What is the nature of the student's mental health impairment? How is the student substantially limited?

Does the student require ongoing treatment?

When did you first meet with the student regarding this mental health diagnosis?

In your opinion, how important is it for the student's well-being that an ESA be in residence on campus? What consequences, in terms of disability symptomology, may result if the accommodation is not approved?



Information about the Proposed ESA

(Please note that there are some restrictions on the kind of animal that can be approved for the residence hall; it is possible the student may be approved for an ESA, based on the information you provide here, but may not be allowed to bring the specific animal named.)

Is the animal named here one that you specifically prescribed as part of treatment for the student, or is it a pet that you believe will have a beneficial effect for the student while in residence on campus?

What symptoms will be reduced by having an ESA?

Is there evidence that an ESA has helped this student in the past or currently?

Please give the ESA's name, type, breed description, age, and weight.

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The student has signed this form (below) indicating written permission to share additional information with us in support of the request.

Signature of certifying professional: _____ Date: _____
Printed name of certifying professional: _____
Professional Title: _____ License #: _____



STUDENT: Please sign this form before providing it to your mental health professional to complete.

By signing below, I give consent for my mental health professional to share with the Disability Resource Center any information relevant to my need for an ESA as an accommodation within the next 60 days.

Signature

Date