



VERIFICATION/REQUEST FORM FOR EMOTIONAL SUPPORT ANIMAL (ESA)

Part I: To be completed by student:

Student Name: _____ Phone #: _____

Proposed ESA Name: _____ Type of Animal: _____ Age of Animal: _____

Residence Hall & Room #: _____

Off-Campus Emergency Contact Name/Phone: _____
(will care for the animal in case of emergency)

I authorize Austin College to receive information from my provider named herein _____
I authorize my provider to discuss my condition(s) with appropriate and qualified Austin College personnel on an as-needed basis.
Student Signature: _____ Date: _____

Attach additional paper if this space is not adequate

Part II: To be completed by health care provider as described below:

A licensed clinical professional/health care provider who fills out this form must be familiar with the history and functional limitations of the above-named student.¹

Complete this form as thoroughly as possible so we may better evaluate the request for this accommodation. Austin College personnel will contact the above-named health care professional if more information is needed:

How long have you treated _____ Date of initial contact _____ Date of last office visit
or counseled student? _____ with student: _____ with student: _____

- 1. Specific disability/disorder (DSM-V), including when student was first diagnosed, severity, and current symptoms:

- 2. Identify the specific limitations/impairment caused by the disability and how this substantially limits one or more major life activities for this student:

¹The provider completing the form cannot be a relative of the student.

² 42 U.S.C. § 3604(f)(3)(B)



3. Explain how the accommodation of an ESA is necessary for the individual to use and enjoy campus housing²:

4. Identify any other accommodations that may be effective in allowing use and enjoyment of housing. If applicable, indicate any mitigating measures that have been tried, or are currently being used, and how they alleviate or eliminate limitations:

5. Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing? Do you believe those responsibilities might exacerbate the student's symptoms in any way?

6. Has the proposed ESA undergone any specific training?

7. Have you discussed with the student, the importance of reading and understanding the College policy on ESAs?

Name of Treating Professional: _____

License #: _____

Address: _____

Phone: _____

Signature of Treating Professional: _____ Date: _____

Please Return Form to:
Director, Academic Skills Center
900 North Grand, Ste. 61544
Sherman, TX 75090
Office: (903) 813-2454
Fax: (903) 813-2038
Email: asc@austincollege.edu

¹The provider completing the form cannot be a relative of the student.

² 42 U.S.C. § 3604(f)(3)(B)