STEPHEN F. AUSTIN STATE UNIVERSITY

Disability Services
P.O. Box 6130, SFA Station • Nacogdoches, Texas 75962
Phone (936) 468-3004 • Fax (936) 468-1368
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For electronic use only

Verification Form for Students Requesting Emotional Support Animals

This form is intended to assist in meeting documentation requirements for students requesting to bring an emotional support animal to live in campus housing. If not thoroughly completed, it may not be sufficient as the sole form of documentation provided. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide documentation of the disability that reflects the current impact on the student's functioning. Present symptoms that meet the criteria for the diagnosis must be noted. To standardize the gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. If the space provided is not adequate, please attach a separate sheet of paper. All information will be kept confidential. Please feel free to contact Disability Services with questions.

The information below is to be completed and signed by the <u>student</u>.

I request and authorize Disability Services, and/or my off-campus provider (name)_____ to release, fax, mail or discuss with each other information related to my request for housing accommodations.

_____
Student Name ID#

_____
Student Signature Date

Email Address: _____ Phone Number: _____

If the information above is left blank or is incomplete it may delay or prevent DS from contacting the student.

The information below is to be completed and signed by the <u>Provider</u>.

1. Please list all DSM-5 or ICD Diagnoses (<u>name and at least one code</u>):

Diagnoses:

1._____ _____ _____

2._____ _____ _____

3._____ _____ _____

4._____ _____ _____

DSM-5 diagnosis name(s) DSM-5 code(s) ICD-10 code(s)

a. Approximate onset of diagnosis

- ☐ Child-approximate age:_____
- ☐ Adolescent-approximate age:_____
- ☐ Adult-approximate age:_____
- ☐ Unknown

b. Date of initial contact with student: _____/_____/_____

c. Date of your last office visit with student: _____/_____/_____

d. Date of your next office visit with student: _____/_____/_____

e. Approximate number of sessions with student: _____

2. Disability Determination

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- ☐ Structured or unstructured interviews with student.
- ☐ Interviews with other persons (i.e., parent, partner, therapist).
- ☐ Completed forms/checklists/screeners.
- ☐ Behavioral observations.
- ☐ Other (Please specify):

_____

b. Describe the symptoms related to the student's condition that cause significant impairment in a major life activity:

_____

_____

_____

c. Current treatment being received by student:
   - ☐ Individual/Group therapy:
     Frequency: _____
   - ☐ Medication management:
     Current medications: _____
   - ☐ Physical / Occupational therapy
     Frequency: _____
   - ☐ Other (please describe):
     _____

d. Severity of symptoms:
   - ☐ Mild
   - ☐ Moderate
   - ☐ Severe

e. Prognosis of disorder:
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

3. Emotional Support Animal Assessment

a. Type of emotional support animal being recommended: _____

b. Please indicate the following:
   - ☐ Student has an existing relationship with an animal.
   - ☐ Student was recommended an emotional support animal but does not yet have one.
   - ☐ Other: _____

c. Provide specific examples of how the emotional support animal functions as treatment or ameliorates symptoms of the student's disability (e.g., explain how the animal reduces anxiety, prevents or shortens episodes, improves sleep, etc.)

_____

_____

_____

_____

d. How were disability-related benefits determined? Please check all that apply.
   - ☐ Direct observation of student with animal present
   - ☐ Direct observation of student without animal present
   - ☐ Student self-report information
   - ☐ Interview information from others (parent, partner, therapist)
   - ☐ Other: _____

Thank you for your help in providing this information. This form should be signed and returned via fax, mail or email to the Disability Services office at SFA.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

_____

State of License: _____ License Number: _____

Address _____
Street or P.O. Box

_____
City State Zip

Phone: _____ Fax: _____

Attach Provider Business Card Here

Please return form to:
Disability Services
PO Box 6130, SFASU
Nacogdoches, TX 75962
Fax: 936.468.1368
Email: disabilityservices@sfasu.edu