Disability-Based Accessible Housing Emotional Support Animal Disability Verification Form

This must be completed by the Treatment Specialist NOT the student

To ensure the provision of reasonable and appropriate services for students with disabilities at SUNY New Paltz, documentation must be provided by a qualified professional, currently treating the student, with experience and expertise in the area for which accommodations are being requested. **The treatment specialist completing this verification form cannot be a family member of the student**. Documentation must be current and provide comprehensive information regarding the student's disability.

By providing the Housing Accommodation Verification materials to a qualified diagnostician/clinician(s), the student is granting permission for a member of the Housing Accommodation Committee at SUNY New Paltz to contact and consult with that professional regarding the student's need for the accommodation.

All requests will be reviewed on a case---by---case basis. Documentation of a disability **does not** guarantee the application will be approved. **Assignments are made only if space is available.**

What semester is this request is being made for?: ____

Assignment to a specific residence area cannot be guaranteed. All requests will be reviewed by the Disability Resource Center, Health Services, the Psychological Counseling Center, Residence Life, and any SUNY New Paltz College office that might be helpful in the decision-making process. It should be noted that medical requests are for an individual, not a group of students.

To be Completed by the Treating Physician or Treatment Specialist:

I am completing this form for (name of student): ____

who is a student at SUNY New Paltz, who has been in treatment with me since __________________ and has requested to bring the **Emotional Support Animal, that I have prescribed as part of a treatment plan, to live in their room on campus. Disability Diagnosis (please list all that apply):**

DSM V code(S): __________________________________ Date of Diagnosis: __________________

Date of last contact with the student: ____________ Total number of visits with student: ____________

What instruments/procedures were used to diagnose the disability?

Anticipated duration of the disability and symptoms: 6 months one year ongoing

Please indicate the accommodations being requested and complete the information regarding the disability and need for the accessible housing accommodations in the space below:

All sections must be completed by the treating Physician or Clinician.

Please type your responses in the boxes below.

ESA as part of a Treatment Plan
When did you begin using the ESA as part of this student's treatment plan?:________________________ What type of animal is the ESA (for dogs, please specify species):____ Age of ESA: ___________ Weight (lbs): _________ Height (ft' in"): _________ Length (ft' in"): ________
Presenting Symptoms of the Disability
Functional Limitations caused by the Disability
How does the ESA mitigate symptoms of the disability
Please explain why the student will not be able to use and enjoy the residence hall without the ESA and give details regarding the **connection between the symptoms and the need for the ESA**

CERTIFICATION OF DISABILITY AND NEED FOR THE ESA

To be completed by the Treating Physician or Clinician certifying the disability and need for the Emotional Support Animal.

Please Read this before signing:

You understand that by completing and signing this form you are certifying that the student has a disability and you have prescribed the ESA as part of your Treatment Plan and the need for the ESA is directly related to the symptoms of the identified disability.

After typing credential and contact information below, please print the form, sign it and use your agency stamp (preferred if you have one) or attach a business card in the box below. Please scan the document and email it to the student.

Print Name of the Medical Professional: ____________________________ Date: ____________________

Credentials Title: _______________________________________ Professional License #: ____________

Name of Medical Practice/Place of Employment: ____

Street Address employer: ____

City: ____ State: _______ Zip Code: ________________

Office Phone: ____________________________ Email: ____

Signature of the Medical Professional: ____

Please use agency stamp or attach your business card here: