New Paltz
STATE UNIVERSITY OF NEW YORK
Disability Resource Center

# DISABILITY BASED ACCESSIBLE HOUSING EMOTIONAL SUPPORT ANIMAL APPLICATION

**PART B: COMPLETED BY THE PROVIDER**

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. 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.**

This request is being made for: ☐ Fall ☐ Spring Year: 20_____

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Assignment to a specific residence area cannot be guaranteed. All requests will be reviewed by the SUNY New Paltz Housing Committee (Disability Resource Center, Student 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 individuals, not a group of students.

**To be Completed by the Treating Physician or Treatment Specialist**

I am completing this form for: _____
Student's First Name Last MI

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 (e.g. 6 months/one year/ongoing): _____

All sections must be completed by the treating Physician or Clinician. Please indicate the accommodations being requested and complete the information regarding the disability and need for the housing accommodations in the space 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 breed)? _____

Age of ESA: _____ Weight (lbs.): _____ Height (ft' in"): _____ Length (ft' in"): _____

**Presenting Symptoms of Disability:**

**Functional Limitations Caused by the Disability:**

**How Does the ESA Mitigate Symptoms of the Disability:**

**Please Explain the Challenges or Barriers the Student Would Face Living in the Residence Hall Without 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 return the completed, signed document to the SUNY New Paltz Housing Accommodation committee by emailing the form to: DRC-housing@newpaltz.edu

First Name _____ Last _____

Credentials/Title _____ Professional License# _____

Medical Practice/Place of Employment _____ (____) Office Number _____

Address of Employer _____ Email _____

City _____ State _____ Zipcode _____ Date _____

Signature _____

Please use agency stamp or attach your business card here: