RESIDENCE LIFE EMOTIONAL SUPPORT ANIMAL ACCOMMODATION REQUEST FORM
CLINICIAN FORM

STUDENT’S NAME (Please Print:)

PROPOSED ESA INFORMATION
Name:
Type of Animal:
Age of animal:
How long has the resident owned the animal?

DISABILITY DEFINITION:
Under Section 504 of the ADA, disability is defined as a physical or mental impairment that substantially limits one or more major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working. "Substantially limited" generally means that a person is unable to perform a major life activity that the average person in a general population can perform. The definition also considers any mitigating measures, such as medication, therapy, etc., the person is engaging in that may relieve the substantial limitations caused by the impairment.

RESIDENT DISABILITY RELATED INFORMATION
1. Does the resident have a disability under this definition? _____ Yes _____ No
2. DSM-5 Diagnosis:
3. Date of Diagnosis: ____/____/____
4. What methods were used to evaluate the student?
5. Date of Last Evaluation: ____/____/____
6. Does the resident require ongoing treatment? _____ Yes _____ No
7. What are the symptoms of this diagnosis/diagnoses, the magnitude, and the frequency?

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<th>Symptom</th>
<th>Magnitude</th>
<th>Frequency</th>
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When completed, please fax to 715-425-0742 or send with the student. If you have questions, contact Alicia Reinke-Tuthill at 715-425-0740 or at ability.services@uwr.edu.
8. Please describe how each diagnosed disability substantially limits the resident’s ability to perform a major life activity as compared to most people in the general population.

______________________________________________________________________________
______________________________________________________________________________
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9. Please explain how the accommodation is necessary for the resident to use and enjoy University housing as compared to the general campus student population?

______________________________________________________________________________
______________________________________________________________________________
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______________________________________________________________________________

10. Is the animal named here one that you specifically prescribed as part of treatment plan for the resident?

   _____ Yes   _____ No

11. Please describe what symptoms will be reduced by having an ESA and how it will aid, support, or provide comfort to the resident?

______________________________________________________________________________
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12. Is there previous evidence that the suggested ESA has helped the resident in the past or currently?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

13. In your opinion, how important is it for the resident’s well-being that an ESA be in residence on campus? What consequences would occur for the resident if the accommodation requested is not approved?

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______________________________________________________________________________

14. 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 may exacerbate the resident’s symptoms in any way?

______________________________________________________________________________

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______________________________________________________________________________

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15. Please identify any other accommodation that may be equally effective in allowing the resident to use and enjoy University housing.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

___________________ ________________________________
Clinician’s printed name Credentials

Professional license # Years in practice 

Clinic/Agency name Phone 

Address

Clinician’s signature Date:

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