

RELEASE OF INFORMATION
FOR VERIFICATION OF A PSYCHOLOGICAL/PSYCHIATRIC DISABILITY
FOR AN EMOTIONAL SUPPORT ANIMAL

The student completes the following:

I, _____, hereby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student's Signature _____

Phone: _____

Student's Z# _____

Date of Birth: _____

Please return the completed information to the appropriate campus:

☐ Florida Atlantic University
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University
Student Accessibility Services
3200 College Avenue, LA 131
Davie, FL 33314
tel: 954.236.1222 fax:
954.236.1123

☐ Florida Atlantic University
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

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INFORMATION FOR DIAGNOSTICIAN

To ensure the receipt of reasonable and appropriate accommodations, students needing services must provide current documentation of their disability. FAU Student Accessibility Services is required to maintain confidential records of this student's conditions for the purpose of accommodation according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendment Act of 2008.

This documentation should provide information regarding the onset, longevity, and severity of symptoms, as well as specifics describing how it interferes with educational achievement. Assessment of current functioning is necessary.

Thank you for your assistance.

**Florida Atlantic University
Student Accessibility Services
DOCUMENTATION OF A PSYCHOLOGICAL/PSYCHIATRIC DISABILITY
FOR AN EMOTIONAL SUPPORT ANIMAL**

Student Accessibility Services (SAS) at Florida Atlantic University (FAU) complies with all federal and state disability laws to ensure equal access for qualifying persons with a disability to educational programs, services, and activities. Please complete the form below to assist SAS in determining appropriate and reasonable disability accommodations for an Emotional Support Animal. To be considered for an Emotional Support Animal accommodation, FAU requires documentation of the student's current condition from the treating licensed clinical professional. This provider must be thoroughly familiar with the student's condition and functional limitations. Please complete this form in total. Additional pages may be attached.

Only a licensed psychologist, psychiatrist, licensed clinical social worker, or licensed mental health counselor are welcome to complete this form:

Student's Name: _____

1. Specific diagnosis/disability (include DSM-5 diagnostic code) _____

2. Date of diagnosis _____

3. Expected duration of the condition _____

4. Procedures/assessments used to diagnose this condition (**ATTACH COPIES** of any psychological evaluation used in making/confirming diagnosis.)

5. Current symptoms and severity of this condition _____

6. Prescribed treatment and/or medications _____

7. Provide dates of psychotherapy for the last six months _____

8. Describe in detail how this condition substantially limits a major life activity (functional limitations) _____

9. How will these limitations interfere with the student's ability to participate in student life, specifically housing and academics?

10. Is the ESA a prescribed part of treatment for this condition? YES NO
If yes, explain what specific symptoms of the disability will be alleviated by the ESA?

11. In your professional judgment, does this person have a disability? YES NO
If yes, how does their disability substantially limit major life activities of this person?

12. Is an ESA necessary to treat this condition? YES NO
If yes, why is it necessary?

13. What species is the ESA? _____

Please note: ESA are limited to one animal unless specific justification is provided to support the necessity of more than one animal.

14. An alternative if the housing accommodation is not available:

CLINICIAN'S NAME (Printed) _____
CLINICIAN'S SIGNATURE _____
CREDENTIALS _____

SPECIALTY, IF ANY _____
LICENSE/CERT. # _____ STATE _____
DATE _____

****Please attach your business card.***