Supporting Documentation for Emotional Support Animal Request

Provider (Physician, Psychiatrist, Social Worker, Mental Health Worker):

Your patient is a student at Wake Forest University and has indicated that having an Emotional Support Animal (ESA) will be helpful in alleviating one or more of the identified symptoms or effects of the student’s disability. To consider this student’s request for an accommodation because of a disability, Wake Forest University requires documentation from the treating and licensed clinical professional or health care provider thoroughly familiar with this student’s condition and his/her functional limitations and/or restrictions.

The information you provide will be used to evaluate the request. Please take the time to complete this form in its entirety.

All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Return Completed Form to:

<table>
<thead>
<tr>
<th>Standard Mail</th>
<th>Electronically</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam Bernot</td>
<td>Email: <a href="mailto:housing@wfu.edu">housing@wfu.edu</a></td>
</tr>
<tr>
<td>Assistant Director, Housing Assignments</td>
<td></td>
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<tr>
<td>Wake Forest University</td>
<td></td>
</tr>
<tr>
<td>1834 Wake Forest Rd., Box 7749</td>
<td></td>
</tr>
<tr>
<td>Winston Salem, NC 27106</td>
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</tbody>
</table>

If the spaces provided are not adequate, please attach a separate sheet of paper.
Information about the Student’s Disability

What is the nature of the student’s mental health impairment?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________  

Date of diagnosis: _________________________________________________

Describe how this condition substantially limits a major life activity. Major life activities “are those basic activities that the average person in the general population can perform with little or no difficulty.” 29 C.F.R. pt 1630
_____________________________________________________________________________________
_____________________________________________________________________________________  

Does the student require ongoing treatment? _______________________________________________

Date of last visit for this condition:____________________________________

How long have you been working with the student regarding this mental health diagnosis?
_____________________________________________________________________________________
_____________________________________________________________________________________  

Information about the Proposed ESA

Is the animal:

☑ An animal that you specifically prescribed as part of treatment for the student
☑ An animal that you believe will have a beneficial side effect for the student while in residence on campus

What symptoms will be reduced by having the ESA?
_____________________________________________________________________________________
_____________________________________________________________________________________  

Anticipated duration of need for accommodation:
_____________________________________________________________________________________
_____________________________________________________________________________________  

Is there evidence that an ESA has helped this student in the past or currently?
_____________________________________________________________________________________
_____________________________________________________________________________________  
Importance of ESA to Student’s Well-being

In your opinion, how important is it for the student’s well-being that the ESA be in residence on campus?
_____________________________________________________________________________________
_____________________________________________________________________________________

What consequences, in terms of disability symptomology, may result if the accommodation is not approved?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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 might exacerbate the student’s symptoms in any way
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. We recognize that having an ESA in the residence hall can be a real benefit for someone with a significant mental health disorder, but the practical limitations of our housing arrangements make it necessary to carefully consider the impact of the request for an ESA on both the student and the campus community.

If you are related to this student what is your relationship?
_____________________________________________________________________________________
_____________________________________________________________________________________

Provider’s Signature:________________________________________
Date:____________________________________________________

Provider’s Name____________________________________________
Address______________________________________________________________________________
_____________________________________________________________________________________

License/Cert. # __________________________ State:_________________________
Specialty___________________________________________________________
Phone:________________________ Fax:________________________________

Affix a business card or apply business stamp within this box: