



**Medical Verification Form – Request for Emotional Support Animal**

Students who request Emotional Support Animals as an accommodation for a disability are required to submit this form to establish the existence of a disability that substantially limits one or more major life activity. In addition, this form must describe the need for the Emotional Support Animal and establish the connection between the disability and the necessity of an Emotional Support Animal as an accommodation.

This information must be completed by a qualified and credentialed practitioner, usually a treating physician or mental health provider, who is not a family member of the student.

**STUDENT CONSENT FOR RELEASE OF INFORMATION**

Student must sign this form before providing it to the Medical/Mental Health Provider.

By signing below, the student grants Rowan University Academic Success Center & Disability Resources (“Rowan ASC”) permission to contact the health provider for additional information, if necessary.

I, \_\_\_\_\_ (print name), hereby authorize Rowan ASC to obtain and/or release information from/to the undersigned provider in order to evaluate eligibility for an Emotional Support Animal. This consent will expire within 60 days.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**DIAGNOSTIC INFORMATION** (Please print)

1. Date of initial contact with the student: \_\_\_\_\_

2. Date of last contact with the student: \_\_\_\_\_

3. Frequency of appointments with student (i.e., once per week, once per month): \_\_\_\_\_

4. Disability Diagnosis(es): Include all pertinent diagnoses. Please be specific with regard to the diagnosed disorder (i.e., specific anxiety disorder, depressive disorder, etc.). Indicate the severity level and descriptive features of each diagnosis: \_\_\_\_\_

5. Date of diagnosis: \_\_\_\_\_



6. Major Life Activities Assessment:

Select which of the following major life activities listed below may be affected because of the diagnosis(es). Indicate the degree to which each activity is impacted. Please add additional life activities in the blank rows, if necessary.

Life Activity	Negligible	Moderate	Substantial	Unknown
Concentrating				
Memory				
Eating				
Social Interactions				
Self-Care				
Stress Management				
Managing Internal Distractions				
Managing External Distractions				
Sleeping				
Organizing				

7. Provide information regarding the student's current presenting symptoms: \_\_\_\_\_

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**INFORMATION ABOUT THE PROPOSED EMOTIONAL SUPPORT ANIMAL (ESA)**

8. Is this an animal that you specifically prescribed as part of a treatment plan for the student, or is it a pet that you believe will have a beneficial effect for the student while in University housing?

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9. What symptoms will be reduced if the student has the ESA in University housing? Please be specific:

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10. How does the need for the ESA relate to the student's ability to use and enjoy the living arrangements provided by the University? \_\_\_\_\_

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11. Is there evidence that an ESA has helped this student, currently or in the past? If yes, please describe in detail: \_\_\_\_\_

\_\_\_\_\_

13. If approved, do the care responsibilities (i.e., feeding, bathing, waste management etc.) of the animal represent challenges for the student that need to be considered or addressed in a particular way? \_\_\_\_\_

\_\_\_\_\_

**PROVIDER INFORMATION**

*Please print, sign, date and complete all fields below*

By selecting this box, I am verifying that the named student information is correct, that the student is a patient that I have been treating, and that I am not a relative of the student.

Provider Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

License or Certification #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Provider Signature: \_\_\_\_\_