EMOTIONAL SUPPORT ANIMAL REQUEST FORM

Student:

Please sign page 1 of this document and submit with the supporting documents to:

Accessibility Resource Center
William Paterson University
300 Pompton Road, Speert Hall, Room 134
Wayne, NJ 07470
Fax: (973)-720-3293
E-mail: ARC@wpunj.edu

Documentation of proof of the following must be provided before your consideration of your request:

_____ Properly licensed according to state and/or local ordinances.

_____ Properly and currently vaccinated.

_____ Letter from veterinary health provider indicating a clean bill of health.

Pages 2-5 of this document must be completed and submitted by a mental health professional.

I confirm that I have read and understand the attached William Paterson University Service/Emotional Support Animal Policy and agree that I consent to these requirements.

Student's Signature: _____ Date: _____

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Student's Name: _____ Student ID # _____

The student named above is applying for disability accommodations and/or services through the Accessibility Resource Center (ARC) at William Paterson University. In order to determine eligibility, a qualified professional must certify that the student has a psychological diagnosis and must provide evidence that it represents a substantial impairment to a major life activity. It is important to understand that a diagnosis in and of itself does not substantiate a disability. In others words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. This documentation form was developed as an alternative to a traditional diagnostic report. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the ARC website. ARC expects the following in regard to this documentation form:

- The form will be completed with as much detail as possible as a partially completed form or limited responses will hinder the eligibility process.
- The form is being completed by a professional who has comprehensive training and direct experience in the differential diagnosis such as a psychologist, psychiatrist, or licensed social worker.
- The professional completing the form is not a family member of the student or someone who has a personal relationship with the student.

Please note: Assessment information that is more than two years old may be considered out of date depending on such factors as the student's current age, student's age at time of assessment and the nature of the diagnosis.

Type of Assistance Animal: _____ Dog Other: _____

Name, breed, size, and weight of animal: _____

How does the assistance animal benefit the individual?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What is the DSM-5 diagnosis for this student?

_____
_____
_____

How long has the student had this diagnosis/condition? _____

What is the severity of the condition? _____ Mild _____ Moderate _____ Severe

Explain the severity indicated above: _____

Explain the duration indicated above: _____

Date of first contact with student: _____ Date of last contact with student: _____

Date(s) current psychological assessment completed: _____

Frequency of appointments with student (e.g., once a week, twice a month): _____

Psychological History – Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable): _____

Pharmacological History – Provide pertinent pharmacological history, including an explanation of the extent to which the medication has mitigated the symptoms of the disorder in the past: _____

Psychosocial History – Provide pertinent information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk-taking or dangerous activities, etc.): _____

What are the student's current symptoms and concerns? _____

Explain how the symptoms related to the student's disorder cause **significant impairment** in a **major life activity** (e.g., learning, eating, walking, interacting with others, etc.) in a classroom and/or residential setting, if applicable.

Provide information regarding the symptoms that cause impairment in **two or more settings** (e.g., work, home, or school etc.), if applicable:

List the student's current medication(s), including dosage, frequency, and adverse side effects:

Are there significant limitations to the student's functioning directly related to the prescribed medications?

_____ Yes _____No

If yes, explain:

Provide an explanation of the extent to which the medication currently mitigates the symptoms of the disorder:

State the student's functional limitations from the disorder specifically in a classroom, educational or residential setting:

_____
_____
_____
_____
_____
_____

Certifying Professional:

_____ _____
Name and Title License #

_____
Company/Office/Institution Affiliation Name

_____ _____
Address Phone #

_____ _____
City, State, Zip Fax #

_____ _____
Signature of Certifying Professional Date

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