UTA Student Access and Resource Center
DIVISION OF STUDENT AFFAIRS

Housing Request for Emotional Support Animal (ESA)

This section to be filled out by the student seeking the accommodation.

Name _____ Student ID#_____

I am requesting the following HOUSING accommodation:

Housing Request for an Emotional Support Animal. *ESAs are commonly kept in households: dog, cat, small bird, rabbit, hamster, gerbil, other rodent, fish, turtle, or other small, domesticated animal traditionally kept in the home.*

Type of Animal: _____

Information for students seeking accommodations and medical providers:

The Student Access and Resource Center (SAR Center) complies with all federal and state disability laws to ensure equal access for qualifying individuals with a disability to educational programs, services, and activities. Registration with the SAR Center as a student with a disability and a complete intake appointment is required.

To determine reasonable accommodations for housing, the SAR Center requests documentation of the student's condition from their treating licensed clinical professional or health care provider. **The qualified provider must be thoroughly familiar with the student's condition and functional limitations and must make a direct connection to the requested accommodation based on the student's current functional limitations. The qualified provider completing this form cannot be a relative of the student, must reside within the student's home state, state of permanent residence or tribal services provider where the student was diagnosed and treated.** *Internet certificates or any other Internet acquired documentation will not be accepted.*

*All documentation submitted to the Student Access and Resource Center is considered confidential. The Student Access and Resource Center may share minimal information with appropriate University staff to process the request.

I authorize The University of Texas at Arlington, Student Access and Resource Center to receive documentation and speak to my current, licensed, qualified clinical professional or health care provider.

Name of Qualified Provider: _____
Print Name of Medical Provider

Student Signature: _____ Date: _____

This section to be completed by attending licensed clinical professional or health care provider:

Print Name and Title: _____

Credentials: _____

Specialty: _____

State of License: _____ License #: _____

Address: _____

Phone: _____ Email: _____

I certify that I conducted or formally supervised and co-signed the diagnostic assessment of this student.

Signature: _____ Date: _____

Date of initial contact with student: _____

Please list all relevant disabilities: _____

_____

Procedure/assessment used to determine this condition (attach copies of results if needed):

_____

Current Severity of Symptoms	*and*	Prognosis of Condition/Disorder
Mild		Good
Moderate		Fair
Severe		Poor

Date of last visit with student: _____

Indicate why/how the student having an ESA in their residence is deemed necessary. Recommendations must be clearly linked to functional limitations of the student's condition.

_____

_____

Thank you for completing this document.