GRAND VIEW UNIVERSITY
1200 Grandview Avenue •Des Moines, IA 50316
FAX 515-263-6192

FORM D

Verification Form for an Emotional Support Animal
("Assistance Animal, Companion Animal")
TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

Student Information:

Student's Name: _____

Proposed ESA:

Type of Animal: _____

Age of Animal: _____

Breed of Animal: _____

This form must be completed by a licensed mental health care provider familiar with the history and functional limitations of the student's condition(s). *The provider completing this form cannot be a relative of the student*. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

The above-named student has indicated that you are the mental health care provider who has suggested or prescribed that having an Emotional Support Animal (ESA) in the residence hall will be helpful in alleviating one or more of the identified symptoms or effects of the student's disability. In order to evaluate this request for this accommodation, please answer the questions below.

Please use the following definition as guidance when completing this form. An Emotional Support Animal (ESA) (referred to as Assistance Animals under the Fair Housing Act) is defined by the United States Department of Housing and Urban Development (HUD) and covers a category of animals that may work, provide assistance, or perform physical tasks for an individual with a disability and/or provide necessary emotional support to an individual with a mental or psychiatric disability that alleviates one or more identified symptoms of an individual's disability, but which are not considered Service animals under the Americans with Disabilities Act. It is typically an animal selected to play an integral part of a person's treatment process and it is not a pet. The animal must demonstrate a good temperament and reliable, predictable behavior. An ESA is prescribed or recommended to an individual with a disability by a mental health professional. An ESA may be incorporated in a treatment process to assist in alleviating the symptoms of that individual's disability. This treatment occurs within the person's residence and, therefore, may be considered for access to university housing.

Information about the Student's Disability (A person with a disability is defined under the Americans with Disabilities Act of 1990 and its amendments as someone who has "a physical or mental impairment that substantially limits one or more major life activities." Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working).

1) Date of Initial Contact with the student: _____/_____/_____

2) Date of Last Office Visit with the student: _____/_____/_____

3) Describe your history with the student and how long you've worked with them (minimum of 4 sessions):

4) When did you first discuss the option of the student having an ESA? Date: _____/_____/_____

5) **Diagnosis:** Please list all relevant diagnosis. If applicable, please list all DSM-V or ICD Diagnosis (text and code):

6) Please include a summary of your professional assessment of the condition and any diagnostic tools used to make the diagnosis.

7) Approximate date of onset: _____/_____/_____

8) Approximate duration of condition: _____

9) Does the student require ongoing treatment? Yes ☐ No ☐

10) Describe the symptoms related to the student's condition that cause significant impairment in a major life activity:

10) **Severity of symptoms:**

- ◯ Mild
- ◯ Moderate
- ◯ Severe

Prognosis of condition(s):

- ◯ Good
- ◯ Fair
- ◯ Poor

Functional Limitations:

Functional limitations should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

Does this condition significantly **limit one or more of the following major life activities**?

	No Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

Information about the Proposed ESA:

11) Is this an animal that you specifically prescribed as part of treatment for this student? Yes☐ No ☐

If yes, please explain how the use of an ESA is part of the student's treatment plan:

If no, please explain:

12) Is there evidence that an ESA has helped this student in the past or currently? Yes☐ No ☐

If yes, please explain:

If no, please explain:

13) How is this animal necessary for the student to have "full benefit or enjoyment" in University housing?

14) How important is it for the student's well-being that the Assistance Animal be in residence with the student?

15) Have you discussed with the student the responsibilities associated with properly caring for this animal while engaged in typical college activities and residing in University housing? Yes☐ No ☐

16) Do you believe these responsibilities might exacerbate the student's symptoms in any way? Yes☐ No ☐

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to the Director of Accessibility Services at the address shown at the end of this document.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____Date: _____/_____/_____

Print name and Title: _____

State of License: _____ License Number: _____

Address:

_____

Phone: _____ Fax:_____

Please complete form, sign, and return to:

Crystal Fierro, MS, MA
Director of Accessibility Services

Grand View University
1200 Grandview Avenue
Des Moines, IA 50316
Email: cfierro@grandview.edu
Phone: 515-263-2971
Fax: 515-263-6192

Attach Provider Business Card Here

*Final determination of appropriate accommodations will be determined by the Director of Accessibility Services at Grand View in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.