Verification Form for Emotional Support Animal Housing Accommodations

Student Name: ______________________  K # ______________________

I authorize the TAMUK Disability Resource Center to request and receive information from my medical provider, ______________________. I authorize my provider to discuss my condition(s) with appropriate TAMUK personnel as needed to determine my qualifications for an ESA.

Student signature: ______________________  Date: ______________________

In order to determine reasonable housing accommodations, Texas A&M University-Kingsville requires information reflecting the most currently available documentation of the student’s medical condition which necessitates an ESA from a licensed clinical professional or a qualified health care provider. Many, but not all, states require face-to-face assessments, and some license holders are restricted from treating relatives or from diagnosing clients independently and/or without the clinical supervisor’s approval.

If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional relevant information, including any evaluative reports that may provide a more complete understanding of the student’s condition which necessitates an ESA. Evaluative reports may include comprehensive diagnostic results such as psycho-educational or neuropsychological information.

Please submit documentation to the Disability Resource Center at the address shown at the end of this document. Please do not provide case notes or rating scales without a narrative that explains the results. Incomplete responses and illegible writing may require follow up that may delay the review process. All documentation will be held strictly confidential as a student and health record. This form may be released at the student’s request.

This form must be completed by a licensed clinical professional or qualified health care provider knowledgeable of the medical history and limitations of the student’s condition(s).

1. Date of Initial Treatment: ____________/___________/___________

2. Date of Most Recent Treatment: ____________/___________/___________

   Diagnosis: Please list all relevant diagnoses. If applicable, please list all DSM-V conditions.

   __________________________________________________________
   __________________________________________________________
3. Approximate date of onset of medical condition(s):

__/__/____

Severity:                               Prognosis of treatment:
  o Mild                                  o Good
  o Moderate                               o Fair
  o Severe                                 o Poor

4. Describe the symptoms related to the student’s medical condition that necessitates an ESA that cause significant impairment in a major life activity.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Please state the specific housing recommendations and a rationale as to why these housing needs are warranted based upon the student’s disability. Indicate why the change(s) to the housing environment you recommend are necessary.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for your assistance in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mailed to the DRC office at the address shown at the end of this document. All documentation submitted to DRC is considered confidential.

**Provider Information**

By my signature below, I certify 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: _________________________________

Address: _________________________________

Phone: _________________________________

Please return this form with supporting documentation to:

Disability Resource Center
Student Health and Wellness Department
Texas A&M University--Kingsville
700 University, Blvd MSC 112
Kingsville, TX. 78363
Phone: 361-593-3024 Fax: 361-593-2006