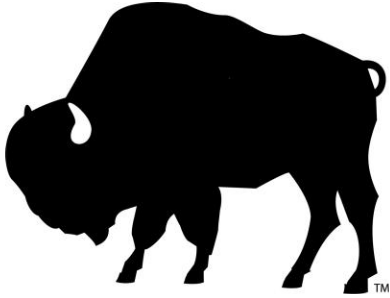

West Texas A&M University

Verification Documentation: Student Disability Services, Housing Accommodations

Part 1: To be completed by the person requesting the accommodation for an ESA:

I am requesting the following Emotional Support Animal: ______________________

Student Name: [ ] Buff ID: ________________

Filled out by the Student:

I authorize West Texas A&M University Student Disability Services to receive information from my primary health care provider, ____. I authorize my primary health care provider to discuss my condition(s) with the appropriate and qualified West Texas A&M University personnel on an as needed basis.

Student Signature: __________________________________ Date: ________________

In order to determine reasonable accommodations or housing, West Texas A&M University requires current and comprehensive documentation of the student's condition from a licensed clinical professional or primary health care provider. *The provider completing this form cannot be a relative of the student.* If the space provided is not adequate to complete the necessary information, please attach additional documentation. The primary health care provider may also attach a report providing additional relevant information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). It is to be filled out by the student's primary professional health care provider within their home state or state of permanent residence where the student was diagnosed and treated.

Part 2: To be completed by the student's Primary Health Care Provider:

1. Date of Initial Contact with Student: _______/_______/_______
2. Date of Last Office Visit with Student: _______/_______/_______
3. Next Scheduled Office Visit with Student: _______/_______/_______
4. *Diagnosis*: Please list all relevant diagnoses. If applicable, please list all DSM-IV or ICD Diagnoses **(text and code)**.

   ____
   ____
   ____
   ____

5. Approximate onset of diagnosis: _______/_______/______

Severity of Symptom's:	Prognosis of Disorder:
Mild _____	Good _____
Moderate _____	Fair _____
Severe _____	Poor _____

6. Describe the symptom's related to the student' condition that cause significant impairment in a major life activity:

   ____
   ____
   ____
   ____

7. Please state the specific recommendation regarding housing, and a rational as to why these housing needs are warranted based upon the student's disability. Indicate why the change(s) to the Residential Housing environment you recommend are necessary.
   ____
   ____
   ____
   ____

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

Provider Information: *Please include the following bulleted information as part of the overall submission.*

- *Signature:* _________________________________
- *Date:* _________________
- *Printed Name and Title:* ____________________________________
- *State of License:* ________________________
- *License Number:* ______________________
- *Address:* ____________________________________
- *Phone Number:* _________________________
- *Fax Number:* ________________________
- ***Business Card: Attached***

Please return information to:
West Texas A&M University
Student Disability Services
Box 60904
Canyon, Texas 79016-0001,
Or Fax: 806-651-2926,
Or by email to sds@wtamu.edu

Please attach a Business Card prior to submission