



EASTERN CONNECTICUT STATE UNIVERSITY

83 WINDHAM STREET • WILLIMANTIC, CONNECTICUT 06226 • 860-465-5000

The Office of AccessAbility Services Documentation of Disability Form – Support Animal

Dear Provider:

The Office of AccessAbility Services (OAS) at Eastern Connecticut State University complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services and activities.

This form should be completed by the student’s current mental health provider who has prescribed a support animal as part of the student’s ongoing treatment in alleviating one or more of the identified symptoms of the student’s diagnosis.

Please note:

- This form must indicate that 1) The student has a disability and; 2)The animal is necessary, as prescribed by the student’s current mental health provider, to give the student with a disability an equal opportunity to use and enjoy University residence halls and there is an identifiable relationship between the disability and the support provided by the animal.
- Any documentation provided to the OAS becomes part of the student’s “educational record,” pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protection and access provisions of FERPA, the student has the right to inspect his or her own educational records, if requested.

Use mouse or **TAB** key to proceed through the form, **SHIFT+TAB** to go back.

TO BE COMPLETED BY MENTAL HEALTH PROFESSIONAL	
Student’s Name:	Date:
Student’s DOB:	
Practitioner Name & Title:	
Name of Clinic or Private Practice:	
Phone:	Fax:
Address:	
License or Certification Number:	State:
Specialty/qualification/ training to make disability determination and support animal prescription:	
Date of last appointment:	Next appointment:





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SECTION I – DIAGNOSTIC INFORMATION

Formal Diagnosis (*per the DSM V or ICD, if applicable*):

Date of diagnosis and expected duration (*temporary, permanent, chronic, episodic/recurring*):

Rationale or methodology used to reach the diagnosis:

Symptoms that meet the criteria for diagnosis:

Current medication(s), dosage frequency, and adverse side effects:

Frequency of treatments/therapies, including recent or anticipated hospitalizations:





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SECTION II – DETERMINATION OF DISABILITY

**Please discuss the impact of the diagnosis on the student’s functioning in a college environment.
Which major life activities are substantially limited by the diagnosis?**

How does the diagnosis impact or impair the student in the residence hall environment?

Please note: To be eligible for services/accommodations, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act and Amendments (ADAA).

These laws define a person with a **disability** as one who:

- (1) has a physical or mental impairment which substantially limits one or more major life activities, or
- (2) has a record of such an impairment, or
- (3) is regarded as having such an impairment.

Substantial Functional Limitation: Client is restricted in comparison to the average person in the general population as to the conditions, manner, or duration under which major life activities can be performed.

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, working, and functions including, but not limited to, the immune system, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, and reproductive functions.

Accommodations: Modification to policy, procedure, or practice which may include the provision of auxiliary aids and services designed to afford students with disabilities equal access to all programs and activities.





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SECTION III – SUPPORT ANIMAL PRESCRIPTION

Breed of support animal: _____

Is this animal prescribed as part of the student’s mental health treatment? **Yes** **No**

What symptoms have you observed or determined to be reduced by the presence of the support animal?

Please discuss the impact on the student’s ability to function at Eastern if the above request cannot be met.

Provider’s Signature: _____

Date: _____

To:
AccessAbility@easternct.edu

Office of AccessAbility Services (OAS)
Wood Support Services, Room 201
Eastern Connecticut State University
83 Windham Street, Willimantic, CT
Phone: (860) 465-5573
Fax: (860) 465-0136

Affix business card, stamp, or type in this box.

Name: _____

Telephone: _____

Fax: _____

Email: _____

Practice: _____

Address, City, State, Zip: _____

