



**REQUEST FOR CERTIFYING PROFESSIONAL’S DOCUMENTATION  
for an EMOTIONAL SUPPORT ANIMAL (ESA)**

The student below has requested an Emotional Support Animal (ESA) in his/her residence hall. You were identified as the professional (physician, psychiatrist, mental health worker) who has been, or is currently, treating the student and are thus able to provide information that can assist the University in its decision whether to waive its no pets policy in light of the Housing and Urban Development’s (HUD) regulations regarding assistance animals in residential dwellings. We accept documentation from providers in either Rhode Island or the student’s home state, only. Please note that letters purchased over the internet based on limited contact between a student and provider in a relationship begun for the sole purpose of obtaining ESA documentation, generally do not provide the information necessary to support the request for accommodation.

So that we may better evaluate the student’s request for this accommodation, please answer the following questions (questionnaires not filled out completely will result in a delay in processing and a potential denial of the student’s request). PLEASE WRITE LEGIBLY:

**Student’s Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Today’s Date:** \_\_\_\_\_

**Information about the Student’s Condition:**

Does this student have a mental or physical impairment that substantially limits one or more major life activities?<sup>1</sup>  
YES                      NO

What is the student’s medical or DSM 5 diagnosis? \_\_\_\_\_

Does the student require ongoing treatment?      YES      NO      If yes, please briefly describe the nature and frequency of this treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In what way(s) does the student’s condition substantially limit their ability to benefit fully from university housing?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial date of contact with student: \_\_\_\_\_

How often did/do you meet with the student (per week, month or other)? \_\_\_\_\_

\_\_\_\_\_ If contact has ended, when was the last visit? \_\_\_\_\_

**Information about the Proposed ESA:**

**Proposed ESA:**

Animal’s name (if known): \_\_\_\_\_

\_\_\_\_\_

<sup>1</sup> The ADA defines a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment” ([www.ada.gov/cguide.htm](http://www.ada.gov/cguide.htm)).

Type of animal: \_\_\_\_\_

Animal's age:   Baby       Young       Adult       Aging

Is the animal housebroken or trained to a litter area?   YES       NO

Is the animal under the student's complete control?   YES       NO (explain why): \_\_\_\_\_

Is the animal the student's or the family's pet?   YES       NO       OTHER: \_\_\_\_\_

Is the animal a part of ongoing treatment for the student (i.e., pet assisted therapy)?   YES       NO

If 'Yes', please describe: \_\_\_\_\_

If 'No', what symptoms of the student do you believe will be reduced by the ESA that cannot be as easily obtained through other means (e.g. therapy, medication, etc.)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What evidence can you provide that an ESA has helped this student in the past or currently?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your opinion, how important is it for the student's well-being that the ESA be in residence on campus? What consequences, in terms of disability symptomology, may result if the accommodation is not approved?

\_\_\_ Unimportant       \_\_\_ Mildly Important       \_\_\_ Moderately Important       \_\_\_ Extremely Important

Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing?   YES       NO       OTHER: \_\_\_\_\_

Could those additional responsibilities exacerbate the student's symptoms in any way?   YES       NO       (If 'Yes', please explain):

\_\_\_\_\_  
\_\_\_\_\_

**Provider information (required):<sup>2</sup>**

Name (print): \_\_\_\_\_

Professional Signature: \_\_\_\_\_

Professional Title or Role: \_\_\_\_\_

License #: \_\_\_\_\_ State: \_\_\_\_\_

**Please return this document to:**

**Disability Services  
Salve Regina University  
100 Ochre Point Ave., Newport RI 02830  
Office: 401-341-3150; Fax: 401-341-2912  
Email: [disabilityservices@salve.edu](mailto:disabilityservices@salve.edu)**

THANK YOU!

<sup>2</sup> The University reserves the right to contact professionals at a later date with further questions.