Linn-Benton Community College

CENTER FOR ACCESSIBILITY RESOURCES
EMOTIONAL SUPPORT ANIMAL ELIGIBILITY FORM

ATTENTION (Professional's Name): _____

ORGANIZATION: _____

ADDRESS (Street, City, State): _____

PHONE: _____ **FAX:** _____

The student named below has requested and Emotional Support Animal (ESA) as a disability accommodation at Linn-Benton Community College.

- A disability is defined in Section 504 of the Rehabilitation Act and Americans with Disabilities Act.
- This student has indicated that you are the health provider who has suggested that having an Emotional Support Animal will help alleviate one or more identified symptoms or effects of their disability.
- This student is consenting to the release of diagnoses, statements of impact, recommended accommodations, opinions on degree of disability, medication records, and psychological/intelligence/ ability/cognitive testing.

Please answer the questions on the reverse side of this form, or send applicable documentation answering the questions to the confidential fax number listed below to help determine the eligibility for an ESA accommodation.

- Your responses will be held in the strictest confidence, per FERPA privacy/records laws.
- If you cannot release information for any reason, please notify the student and return this form to our office with a brief explanation.
- If you need in-house forms completed in your office, please contact the student directly.

STUDENT (Please Print Name): _____

BIRTHDATE: _____ **OTHER NAMES:** _____

STUDENT'S PHONE NUMBER: _____

PROPOSED EMOTIONAL SUPPORT ANIMAL'S NAME: _____

TYPE OF ANIMAL: _____ **AGE OF ANIMAL:** _____

IS THE ANIMAL LICENSED BY THE COUNTY? (You may be asked to provide proof.)**:** _____

I consent to the disclosure of the following information: Medical records **Initial** _____
Mental health records **Initial** _____

Permission is granted for up to 90 days, or until this release is revoked by written notice.

By signing below, I consent to the faxing of this release to the above-mentioned party and to the response/ records delivered pursuant to this release of documentation:

STUDENT'S SIGNATURE: _____ **DATE SIGNED:** _____

SEND TO: Center for Accessibility Resources, Attention: Julie
Linn-Benton Community College · 6500 Pacific Blvd. SW, RCH-105 · Albany, OR 97321
Email: cfar@linnbenton.edu Fax: 541-917-4328 Phone: 541-917-4789

THIS SIDE TO BE COMPLETED BY DIAGNOSING PROFESSIONAL ONLY

STUDENT: _____ DOB: _____ DATE: _____

Diagnosis (include all conditions relevant to disability along with DSM-IV codes) and date of onset (if known):

_____

_____

What is the student's current treatment (medication, counseling, etc.), and is it ongoing?

_____

_____

How long, and with what frequency, have you been working with the student regarding this diagnosis?

_____

_____

Do you specifically prescribe the proposed ESA as part of treatment? _____

How does the diagnosed condition <u>significantly impact</u> this student's ability to participate in or access college?

_____

_____

INFORMATION ABOUT THE PROPOSED ESA:

What disability symptoms will be reduced by having an ESA at school, and how specifically will they be reduced?

_____

_____

What evidence exists that the ESA has helped this student currently or in the past?

_____

_____

What consequences, in terms of disability symptoms, may result if the accommodation is not approved?

_____

_____

_____/_____/_____

Signature of Diagnosing Professional **Title** **Printed Name**

Type of License: _____ License #: _____ Expiration Date: _____

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