ACCESSIBILITY AND DISABILITY SERVICES
8000 YORK ROAD
TOWSON, MD 21252
T. 410-704-2638
F. 410-704-4247
www.towson.edu/ads

**REQUEST FOR EMOTIONAL SUPPORT ANIMAL IN UNIVERSITY HOUSING VERIFICATION FORM**
****must be completed by a licensed mental health provider**

Under the Fair Housing Act (FHA), in order to qualify for an Emotional Support Animal (ESA), the animal "must be necessary to afford the individual an equal opportunity to use and enjoy a dwelling or to participate in the housing service or program." Further, there must be a relationship, or nexus, between the individual's disability and the assistance the animal provides.

Having an ESA in the student's residential living space can be a reasonable accommodation for students with mental health disabilities, but due to the nature of our housing arrangements it is necessary to carefully consider the impact of having an ESA on both the student and the residential community. To help us evaluate the student's request, we require documentation from a licensed and/or certified mental health care professional (e.g., psychiatrist, clinical psychologist, licensed clinical social worker or licensed certified professional counselor) who is currently treating the student and suggests an ESA to help alleviate one or more identified symptoms or effects of the student's disability. We accept documentation from a provider in the state of Maryland or the student's home state, and who is not a close friend or relative of the student. After completing this form, fax or mail it to Accessibility & Disability Services (ADS) at the address above.

1. Student's Name_____DOB_____Today's Date_____
2. Type of Proposed ESA _____Name (if known) of Proposed ESA_____
3. Is this an animal that you have specifically recommended as part of the student's treatment? _____YES_____NO
4. What is the student's mental health impairment/qualifying disability?
5. When did you first meet with the student regarding this mental health disability?
6. When did you last meet with the student? _____
7. How often do you see the student? _____
8. What symptoms does the student experience as a result of this disability?
9. How do these symptoms impact the student's functioning?

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10. How does the presence of an ESA mitigate the limitations created by the student's disability?

11. What evidence is there that an ESA has helped the student in the past or currently?

12. What consequences in terms of disability symptomology may result if the accommodation was not approved?

13. Please note that the student is solely responsible for the control, care and supervision of the ESA at all times. Do you believe these responsibilities above might exacerbate the student's symptoms in any way?

### SIGNATURE OF LICENSED MENTAL HEALTH PROFESSIONAL

As the provider you must be familiar with the history and functional limitations of the student's disability. You are not eligible to complete this form if you are related to the student or a close friend.

I verify that this form has been completed by me or a designated staff member, that I am treating this student, and that I am not a relative or close friend of the student.

Printed Name/Credentials/Field_____

Signature_____ Date_____

License number_____

Address_____

Phone_____Fax_____