Verification Form for Assistance Animal Accommodations

I authorize Southern Arkansas University Tech Housing and Disability Support Services to receive information from my provider (name) _____. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Southern Arkansas University Tech personnel on an as needed basis.

Student Signature _____Date_____

Student Name: _____Student ID:_____

In order to determine reasonable accommodations for housing, Southern Arkansas University Tech requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider. **The provider completing this form cannot be a relative of the student**. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related 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).

1. Date of Initial Contact with Student: _____
2. Date of Last Office Visit with Student:_____
3. **Diagnosis:** Please list all relevant diagnosis. If applicable, please list all DSM-V or ICD Diagnosis (text and code):_____
   _____
   _____
4. Approximate onset of diagnosis: _____/_____/_____
5. What is the functional impact or limitations of the disability on learning or other major life activity and the degree to which it impacts the individual in the learning context for which accommodations are being requested?_____
   _____
   _____
   _____

SOUTHERN ARKANSAS UNIVERSITY TECH
P.O. Box 3499 Camden, AR 71711-1599 870.574.4500

6. Describe the symptoms related to the student's condition that cause significant impairment in major life activity. _____
_____
_____
_____

7. Please state any specific recommendations regarding housing and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the change(s) to the housing environment you recommend are necessary. _____
_____
_____
_____

8. What species of service, therapy, or emotional support animal is necessary for this student?_____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to SAU Tech Disability Support Services at the address shown at the end of this document.

PROVIDER INFORMATION
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above. Signature: _____Date:_____ Print Name and Title:_____ State of License: _____License Number:_____ Address: _____ Phone: _____Fax: _____

Please return this form to: Southern Arkansas University Tech Disability Support Services PO Box 3499 Camden, AR 71711 Phone: (870) 574-4530 Fax: (870) 574-4734	**Please attach business card here:**

SAU Tech Office use only:	
Disability Services Approval:	YES or NO
Disability Support Services Signature:	_____
Date:	_____