Support Animals Request Form

Students with psychiatric disabilities who request the assistance of an emotional support animal may request an accommodation through Disability Support Services (DSS). Requests for housing accommodations are reviewed by committee based upon necessity to ensure equal access to the housing program. This form must be completed by the student’s current treating physician, psychiatrist, social worker, or other mental health professional.

Directions to Students:
- You must complete the 2022-2023 Housing Accommodation Request Form in addition to this form
- Sign the Consent for Release and Exchange of Confidential Information as DSS staff will speak to your provider. Sign any applicable releases with their office to speak with us.
- Provide the form to your qualified treatment provider to complete Part II
- Return the entire form to DSS by March 6, 2022 for current students, and May 1, 2021 for new incoming students. Consideration of requests after the deadline may be limited based on availability.

Part I: Student to complete the following

Please print clearly

Name: ______________________________________________________________

SHU ID#: __________________________________________________________

Student Cellular #: _________________________________________________

SHU Email: _________________________________________________________

Status/Campus: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Transfer

Accommodation Request is for: ☐ Fall ☐ Spring ☐ Summer Year: ________

Consent for Release of Information (to be completed by student):

I authorize ________________________ (physician or evaluator’s name) to disclose the information requested by this form to the office of Disability Support Services at Seton Hall University for the purpose of evaluating my request for housing accommodations. I also allow both parties to discuss any information related to my housing accommodation request. I understand that my personal medical information will be shared on a “need to know basis” with other university offices.

Student Signature: __________________________________________Date: ___________
Part II: Physician or Disability Evaluator Verification

Directions: Please print clearly or type. Please answer all questions thoroughly. Insufficient documentation may result in accommodation delays or denial.

Is the student currently under your care? __________ Yes _____ No

What is the student’s diagnosis? ____________________________________________

Are you the prescriber of the emotional support animal? __________ Yes _________ No

If yes, when did you prescribe the emotional support animal? (Date: mm/dd/yyyy) ________________

How long has the student had an emotional support animal? ________________________________

What type of emotional support animal did you recommend? ________________________________

Is the request an integral component of a treatment plan for the condition in question? _____ Yes _________ No

Describe the student’s functional limitations or behavioral manifestations caused by the condition. What do you foresee as the impact living in a college residential hall setting? _______________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Please explain how the emotional support animal ameliorates the effects of the disability: ________________________________

__________________________________________________________

__________________________________________________________

Would you consider other accommodations to be a reasonable alternative to an emotional support animal (ie., single room, preference in choosing housing assignment, other.)? Please explain: ________________________________

__________________________________________________________

__________________________________________________________

Is there a negative health impact that may be permanent if the request is not met? __________ Yes _________ No

What is the likely impact on academic performance if the request is not met? ________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
What is the likely impact on social development if the request is not met? __________________________________________________

______________________________________________________________

What is the likely impact on the student’s level of comfort if the request is not met? _________________________________________

______________________________________________________________

THIS SECTION MUST BE COMPLETE FOR FORM TO BE VALID

Physician or disability evaluator INFORMATION (Please Print)

Name: __________________________________________________________
Title: __________________________ Specialty: _________________________
Office Address: _________________________________________________
Phone: __________________________
License/Certification Number and State of License __________________________
How long have you treated this patient? _____________________________
Date of most recent office visit? _____________________________
May we contact you if we have questions about this student’s accommodation request? _____Yes _________No

Signature: ___________________________ Date: ______________________

PLEASE MAIL, FAX or EMAIL COMPLETED FORM TO:
Disability Support Services
Seton Hall University
400 South Orange Avenue, South Orange, NJ 07079
(973) 313-6003 (p), (973) 761-9185 (f)
dss@shu.edu
Consent for Release and Exchange of Confidential Disability Information

Name (Printed Clearly): ________________________________  Student ID: __________________

Address: __________________________________________________________________________

Phone Number: ____________________________  Email: _________________________________

I authorize Seton Hall Disability Support Services Office to release/receive my disability information checked below:

______ My accommodations without specifying my disability.

______ My accommodations and specifying my disability.

_____ My medical/psychological/learning disability documentation (specify provider name): _______________________________

_____ Only the following information related to my accommodations: __________________________________________________________________________________________

_____ To contact my provider (specified here) for purposes of consultation on accommodations:

Name: __________________________________________________________________________________________

Address: _______________________________________________________________________________________

Phone: ________________________________

Release to:

_____ *Student electronically (at email listed above)

_____ *Student will pick up and show student ID to collect.

_____ Send hardcopy to the following person: Name________________________________________________________

Institution/Office Name__________________________________________  Phone: ____________________________

Address: _______________________________________________________________________________________

_____ Send electronically to the following person: Name____________________________________________________

Phone: ____________________________  Institution/Office Name__________________________________________

Address: _______________________________________________________________________________________

Email address: ____________________________  Fax number: ____________________________

*DSS strongly encourages students to take ownership of their documentation and share directly with others

This release expires in 12 months unless another date is specified here: __________________________

Student Signature: ________________________________  Date: ________________________________

DSS Office Use Only: ________________________________  Date Sent: ________________________________