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? ____

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____

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

400 South Orange Ave
Duffy Hall, Room 67
South Orange, NJ 07079
Phone: (973) 313-6003
Fax: (973) 761-9185
Email: DSS@shu.edu

340 Kingsland Street
Suite 1500, Room 1519
Nutley, NJ 07110
Phone: (973) 542-6978
Fax: (973) 542-6400
Email: carolyn.corbran@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: ______________________