SAN JUAN COLLEGE

PROVIDER QUESTIONNAIRE FOR EMOTIONAL SUPPORT ANIMAL

(Do not use this form to document the need for General Housing Accommodations)

Student's Name: _____ DOB _____

Phone: _____

By signing below, I consent to allowing my healthcare provider to share any information relevant to my need for an ESA as an accommodation, as shown on this form, with Disability Services for the next 60 days (about 2 months).

Student Signature: _____ Date _____

Dear Licensed Clinical Professional or Healthcare Provider

The above-named student has made a request to receive permission to keep an Emotional Support Animal (ESA) in campus housing. To evaluate the student's request for a housing accommodation of an Emotional Support Animal at San Juan College, the Accessibility Services Office requires specific information from a licensed clinical professional or healthcare provider who is responsible for the treatments of the student's diagnosed disability, including the use of an ESA.

The healthcare provider need not use this specific form but all information requested here is necessary for the institution to have in order to consider the request for an ESA; the form is provided as a convenience.

We ask that you please complete this form in its entirety, providing complete answers to all questions. Please explain if you are unable to provide a response to a question. It is not necessary to provide additional documentation for this student's request, however if you feel that additional information may provide a more complete understanding of the student's request you are welcome to include additional information.

Please do not hesitate to contact our office (phone: 505-566-3271) with any questions or concerns. Your assistance with our evaluation of the student's request is greatly appreciated.

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How to Submit

Once this form has been completed, it should be sent to Accessibility Services. The student can upload this form to their application, or it can be scanned and emailed to ASO directly by the student or healthcare provider via the contact information below:

Accessibility Services Office
San Juan College
4601 College Blvd, Farmington, NM 87402
Email: accessibilityservices@sanjuancollege.edu
Phone: 505-566-3271
Fax: 505-566-3455

PROVIDER QUESTIONNAIRE

Information About the Student's Disability

Federal law defines a person with a disability as someone who has a physical or mental impairment that substantially limits one or more major life activities. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation).

1. What is the nature of the student's mental health impairment (that is, how is the student **substantially limited**?)

2. Does the student require ongoing treatment?

3. When did you first treat the student regarding this mental health diagnosis?

4. When did you last interact with the student regarding his mental health diagnosis?

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Information About the Proposed ESA

1. If the student currently has an ESA, is it one that you specifically prescribed as a part of treatment for the student, or is it a pet that you believe will have a beneficial effect for the student while in residence on campus?

2. What specific symptoms will be reduced by having an ESA, and how will those symptoms be mitigated by the presence of the ESA?

3. Is there evidence that an ESA has assisted the student with the above referenced condition in the past or currently?

Importance of ESA To Student's Well-Being

1. In your opinion, how important is it for the student's well-being that an ESA be in residence on campus?

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

3. This student was provided with a copy of the rules and restrictions surrounding the presence of an animal in the residence in the college housing. Has the student shared those restrictions with you? (Yes or no)

4. Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and living in campus housing? Do you believe those responsibilities might exacerbate the student symptoms in any way?

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Certifying Licensed Medical or Mental Health Professional

By signing below, you are verifying that you were solely responsible for completing this form, the information reflects your responses to the questions, you are treating this student, and are not a relative of the student.

Printed Provider Name: _____

Title: _____

Area(s) of Specialization: _____

State of Licensure/Certification: _____

License/Certification Number: _____

Phone Number: _____

Fax: _____

Provider Signature: _____

Date: _____