**Martin Luther College**

**Request for Emotional Support Animal**

Send to: Office of Student Life

1995 Luther Ct

New Ulm, MN 56073

**Student fills out the section below. Please print or type.**

# Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First M.I.

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**: I authorize the provider listed below to release information related to my request to Martin Luther College for the purpose of an accommodation to my housing assignment because of a disability, and to discuss this request with VP for Student Life or his representative. This authorization is valid for the duration of the request for accommodation, effective from the date below.

Name of Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State and Zip)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

*(Continued on next page)*

### Medical/Health Care Provider provides information requested on signed letterhead

**REQUEST FOR INFORMATION**

\*Student should fill in top portion before their appointment

\*Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Re: Proposed Emotional-support Animal:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Type of animal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Age of animal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are the psychologist/psychiatrist who is treating: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student’s name). You have suggested that having an Emotional Support Animal (ESA) in the residence hall will be necessary in alleviating one or more of the identified symptoms or effects of the student’s disability. So that we may better evaluate the request for this accommodation, please answer the following questions on your signed letterhead:

*(A person with a disability is defined as someone who has “a physical or mental impairment that substantially limits one or more major life activities.”)*

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? If so, please provide the treatment plan.
3. Please describe the specific type of animal you are prescribing.
4. Is the specific animal described above **therapeutically necessary** for the treatment of the students’ diagnosed psychiatric disability?
5. Is there evidence that an ESA (emotional support animal) has helped this student in the past or currently? If yes, how so?
6. Is there evidence that an ESA is necessary for academic success? If yes, explain?
7. Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing? Do you believe those responsibilities might exacerbate the student’s symptoms in any way?

Thank you for taking the time to complete this form.

Please include contact information and the above requested information, and return it to the Vice President for Student Life at:

[schonejl@mlc-wels.edu](mailto:schonejl@mlc-wels.edu) or Fax to: 507-354-8225

Provider contact information:

Address:

Telephone:

FAX and/or Email address:

Professional Signature:

License #:

Date: