Student Services

SIMPSON COLLEGE

Accessibility

MEDICAL OR MENTAL HEALTH CARE PROVIDER DOCUMENTATION FOR STUDENT REQUEST FOR EMOTIONAL SUPPORT ANIMAL (ESA)

THIS MUST BE RETURNED TO SIMPSON COLLEGE BY THE PROVIDER. See last page for details.

Patient Name (First and Last): _____

DOB: _____

Proposed ESA: Type of animal: _____ Age of animal: _____

Length of relationship with animal:_____years _____months

TO THE APPLICANT: By signing below, I consent to allow my health provider to share information relevant to my need for an Emotional Support Animal (ESA) as an accommodation with Simpson College Student Accessibility Services.

SIGNATURE: _____

DATE: _____

TO THE HEALTHCARE PROVIDER: The person above is seeking, under the Fair Housing Act, to apply for an Emotional Support Animal (ESA) in campus housing. If you are the treating health care provider who has recommended that having an ESA in the residence hall will have therapeutic benefit in alleviating one or more of the identified symptoms or effects of the person's health condition, we ask that you please complete this documentation form.

DOCUMENTATION confirming a condition-related need for an emotional support animal:

We accept documentation from appropriate health care providers licensed in the state of Iowa or the person's home state who have personal knowledge and a history of treatment of the above individual, consistent with their professional obligations. **Documentation must be from the person's health care provider who is not a relative of the person.**

Supporting documentation consists of information from a licensed healthcare professional (e.g., psychiatrist, psychologist, physician, physician's assistant, nurse practitioner, nurse), general to the condition but specific as to the individual with a disability and the therapeutic emotional support provided by the animal. **A relationship or connection between the disability and the need for support animal MUST be provided.**

To better evaluate the request for accommodation, please answer the following questions:

A. **Disability and Accommodation-Related Information.** Please provide information regarding the substantial limitation(s) and the recommendation for an emotional support animal. Include a clear rationale or nexus between the functional limitation and the requested accommodation.

1. Does the patient have a physical or mental impairment? _____Yes _____No

2. Does the patient's physical or mental impairment substantially limit one or more major life activities or major bodily functions? _____ Yes _____ No

3. Does the patient need the animal because it provides therapeutic emotional support and/or alleviates one or more symptoms or effects of the disability of the patient, and not merely as a pet? _____ Yes ____ No

4. Please describe how the animal ameliorates the symptoms or effects of the disability of the patient or otherwise provides therapeutic emotional support.

5. In your professional opinion, is the animal named at the beginning of this document necessary for the individual to (check all that apply):

   _____ use Simpson College as a working and residential institution?

   _____ enjoy Simpson College as a working and residential institution?

B. **Unique Animals.** If the proposed animal is not a dog, cat, small bird, rabbit, hamster, gerbil, other rodent, fish, turtle, or other small domesticated animal that is traditionally kept in the home for pleasure and not commercial purposes, please answer the following questions:

(1) Date you lasted consulted with the patient regarding the need for this particular animal or particular type of animal: _____

(2) Please describe any unique circumstances justifying the patient's need for this particular animal (if already owned or identified by the patient) or particular type of animal:

(3) Please describe any reliable information in your possession about this particular animal and whether you specifically recommended this particular animal or type of animal as an emotional support animal for the patient and reasons therefor.

C. **Professional Relationship.** I hereby represent that the named individual's information is correct; that the individual is a patient with whom I have a professional relationship and have been treating and providing disability-related care and services; and that I am not a relative of the patient.

Date first seen: _____

Date of most recent visit or telehealth consultation: _____

Provider Name (print): _____ Credentials/License #: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax/Email: _____

SIMPSON COLLEGE

Please submit this documentation as an attachment and email to:

sas@simpson.edu
OR
Fax 515-864-0437
OR
Via U.S.Mail to:
Simpson College
Student Accessibility Services
701 N C St.
Indianola, IA 50125

All documentation and records provided will be maintained in a confidential manner as outlined in the Family Rights and Privacy Act (FERPA) of 1974. Disability information is shared only on a limited basis within the college and then, only when there is a compelling reason for the individual seeking the information to have knowledge of a specific aspect of this confidential information. Disability-related records are maintained separately from academic files and are excluded from free access under FERPA.

Revised 05/03/2024 /. KL