Logo of the Student Disability Access Center at the University of Virginia

**ADDENDUM TO DOCUMENTATION:**

**SUPPORT FOR REQUest FOR AN EMOTIONAL SUPPORT ANIMAL IN UNIVERSITY-OPERATED HOUSING**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The student named above has requested access to an Emotional Support Animal (ESA) from the Student Disability Access Center (SDAC) at the University of Virginia. In order to evaluate this request, we require the student’s treating provider to fill out an addendum to the documentation of the student’s disability. Please ensure that you have also filled out the Verification of Disability form in addition to this addendum; both are required. Use additional sheets as necessary.

1. As a qualified health care professional, are you licensed to provide and document services in the state in which the student resides or in the state of Virginia?
2. Is this animal part of an ongoing treatment plan? If yes, please describe.
3. Does the student have an established relationship with the animal, or will it be new to the student?
4. Please provide information on how the animal mitigates the impact of the functional limitations of the student’s disability listed on the Verification of Disability form.
5. Please describe any information that an ESA has helped this student in the past or present.
6. In your opinion, is it important for the student’s well-being that an ESA be in residence with the student? Is there an alternative equally effective accommodation?
7. Do you believe that the student can perform the responsibilities of caring for an ESA?
8. Optional: You may use the space below (and additional sheets as needed)

to provide any other information that you believe will be helpful to SDAC staff in considering the request for an emotional support animal.

**I, the undersigned, certify that the information provided for the aforementioned student is true and correct to the best of my knowledge and belief:**

Treating Provider Signature (if in training, please include supervisor signature) Date

Name (*please print)*

Title / Name of Agency

License # Type of License

Phone Number

Street Address

City/State/Zip

All documentation submitted for consideration to SDAC is confidential. **Please include any available releases the student has signed** authorizing communication between the SDAC and the clinician or treating provider who is submitting this verification and any supporting documentation.