Accessibility Resources & Services
550 North College Avenue
Claremont, CA 91711
Office: 909.621.8017|Fax: 909.607.7228
Email: Disability@pomona.edu

EMOTIONAL SUPPORT ANIMAL (ESA) DISABILITY VERIFICATION FORM

STATEMENT OF ATTENDING HEALTH CARE PROVIDER

The student named below is requesting an ESA on the basis of a disability at Pomona College. We ask you, the healthcare provider treating this student, to please complete this form in its entirety to assist us in the decision-making process for the ESA request. Our office will make the final determintation regarding eligibility. Please write legibly or fill out electronically to avoid any delays.

SECTION 1: STUDENT'S IDENTIFYING INFORMATION

STUDENT NAME: ______________________________ SID:______________ BIRTHDATE (MM/DD/YYYY): _____________

SECTION 2: PROPOSED ESA INFORMATION

ESA NAME: ___________________________________ SPECIES: ____

BREED: ____ AGE OF ANIMAL: _____________________________________

DESCRIPTION OF ANIMAL (INCLUDE SIZE AND WEIGHT):

IS THE ANIMAL LICENSED: ☐YES ☐ NO ☐ N/A

LICENSE ISSUE DATE: _______________________________ LICENSE EXPIRATION DATE: ____________________________

IS THE ANIMAL VACCINATION UP TO DATE: ☐YES ☐ NO ☐ N/A

SECTION 3: TREATMENT HISTORY

DATE YOU FIRST TREATED THE STUDENT FOR THIS CONDITION: ____

LIST THE DATES YOU HAVE TREATED THIS PATIENT FOR THE PAST 12 MONTHS? ____

____

IS THERE A HISTORY OF HOSPITALIZATION FOR THIS CONDITION? PLEASE PROVIDE DATE(S) _________________________________

____

SECTION 4: DIAGNOSTIC INFORMATION

DIAGNOSIS: ____ DSM/ICD CODE: __________________________________

DATE NOTED: _______________________________ SEVERITY: ☐MILD ☐MODERATE ☐SEVERE ☐ IN REMISSION

ANTICIPATED DURATION: ☐ CHRONIC/PERMANENT ☐ TEMPORARY; EXPECTED TO LAST: ____________________________

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SECTION 5: DISABILITY INFORMATION

PLEASE IDENTIFY THE SYMPTOMS CAUSED BY THE DISABILITY AND HOW THEY SUBSTANTIALLY LIMIT ONE OR MORE MAJOR LIFE ACTIVITIES FOR THE STUDENT:

WHY IS AN ESA NECESSARY FOR THIS STUDENT TO EXPERIENCE FULL ACCESS TO THE HOUSING ENVIRONMENT AT POMONA COLLEGE? HOW WOULD AN ESA ALLEVIATE THE FUNCTIONAL LIMITATION(S) THE STUDENT IS EXPERIENCING?

CURRENT TREATMENT PLAN/ FOCUS OF CLINICAL TREATMENT:

CURRENTLY PRESCRIBED MEDICATION(S)	START DATE	CURRENT DOSAGE
______________________________	________________________	_________________________
______________________________	________________________	_________________________
______________________________	________________________	_________________________
______________________________	________________________	_________________________

SECTION 6: PROFESSIONAL CERTIFICATION

By signing below, I am certifying that I am a health care provider who is authorized to practice by the state and performing within the scope of my practice as defined by State laws (29 CFR § 825.125 and AB-468). I also verify that the information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.

____ _______________________________________
PROVIDER'S NAME & SIGNATURE TODAY'S DATE

____ _______________________________________
PROFESSIONAL TITLE & CREDENTIALS LICENSE NUMBER

____
STREET ADDRESS CITY STATE ZIP

(   )_________________ (   )_______________ _______________________________
PHONE FAX EMAIL