RELEASE OF INFORMATION
FOR VERIFICATION OF A PSYCHOLOGICAL/PSYCHIATRIC DISABILITY FOR AN EMOTIONAL SUPPORT ANIMAL

The student completes the following:

I, ____, hereby authorize the release of the following information as well as any pertinent documentation to the Disability Resource Center at the University of Kentucky for the purpose of determining my eligibility for academic accommodations.

Student's Signature ____ Phone: __________________________

Student's ID#____ Date of Birth: ____________________

Please return the completed information to the appropriate the UK campus:

☐ University of Kentucky
Disability Resource Center
725 Rose Street
Lexington, KY 40536-0082
tel: 859-257-2754 fax: 859-257-1980

☐ Dog/Cat
Breed: ________________________________
Age: ________________________________
Color: ________________________________
Rabies:________________________________

☐ Other animal: ____________________
Species: ____________________
Color: ____________________
Vet Record: ____________________
(letter that animal is in good health)

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INFORMATION FOR DIAGNOSTICIAN

To ensure the receipt of reasonable and appropriate accommodations, students needing services must provide current documentation of their disability. UK Disability Resource Center is required to maintain confidential records of this student's conditions for the purpose of accommodation according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendment Act of 2008.

This documentation should provide information regarding the onset, longevity, and severity of symptoms, as well as specifics describing how it interferes with educational achievement. Assessment of <u>current</u> functioning is necessary.

Thank you for your assistance.
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University of Kentucky
Disability Resource Center
DOCUMENTATION OF A PSYCHOLOGICAL/PSYCHIATRIC DISABILITY FOR AN EMOTIONAL SUPPORT ANIMAL

The Disability Resource Center (DRC) at the University of Kentucky (UK) complies with all federal and state disability laws to ensure equal access for qualifying persons with a disability to educational programs, services, and activities. Please complete the form below to assist DRC in determining appropriate and reasonable disability accommodations for a Support Animal. To be considered for an Support Animal accommodation, the University requires documentation of the student's current condition from the treating licensed clinical professional. This provider must be thoroughly familiar with the student's condition and functional limitations. Please complete this form in total. Additional pages may be attached.

Only a primary physician licensed psychologist, psychiatrist, licensed clinical social worker, or licensed mental health counselor are welcome to complete this form:

Student's Name: _____

1. Specific diagnosis/disability (include DSM-5 diagnostic code) _____

_____

2. Date of diagnosis_____

3. Expected duration of the condition _____

4. Procedures/assessments used to diagnose this condition (**ATTACH COPIES** of any psychological evaluation used in making/confirming diagnosis.)

_____

_____

_____

_____

5. Current symptoms and severity of this condition _____

_____

_____

6. Prescribed treatment and/or medications_____

_____

_____

_____

7. Provide dates of psychotherapy for the last six months_____

_____

_____

8. Describe in detail how this condition substantially limits a major life activity (functional limitations) _____

_____

_____

9. How will these limitations interfere with the student's ability to participate in student life, specifically housing and academics?

_____

_____

_____

10. Is the ESA a prescribed part of treatment for this condition? YES ☐ NO ☐
If yes, explain what specific symptoms of the disability will be alleviated by the ESA?

_____

_____

11. In your professional judgment, does this person have a disability? YES ☐ NO ☐
If yes, how does their disability substantially limit major life activities of this person?

_____

_____

_____

12. Is an ESA necessary to treat this condition? YES ☐ NO ☐
If yes, why is it necessary?

_____

_____

_____

13. An alternative if the housing accommodation is not available:

_____

_____

CLINICAN'S NAME (Printed) _____
CLINICIAN'S SIGNATURE_____
CREDENTIALS_____
SPECIALTY, IF ANY_____
LICENSE/CERT. # _____ STATE_____
DATE_____
DRC received date: