Date: _____

Patient Name: _____

Date of Birth:_____

1. First and Last date of treatment with this individual:_____to _____

2. DSM-V Diagnosis _____
    a. Severity
        i. ____Mild
        ii. ____Moderate
        iii. ____Severe

    b. How did you arrive at your diagnosis? Please check all that apply
        i. ____ Behavioral Observations
        ii. ____ Developmental History
        iii. ____Educational History
        iv. ____ Medical History
        v. ____ Clinical Interview (Structured or Unstructured)
        vi. ____ Interviews with others
        vii. ____ Rating Scales
        viii. ____ Other –Please Specify_____

3. What functional limitations are present as a result of this individual's disability? How do the limitations impact the individual's ability to perform major life activities?

4.

_____m maj aci

6. What consequences, in terms of disability symptomology, may result if this accommodation is not approved?

7. What type of animal is being requested to be used as the Emotional Support Animal?

Healthcare Provider Information

Provider name (Print):_____

Provider Signature:_____

License or Certification Number:_____

Address:

Phone:_____

Fax:_____