ACCESS CENTER

Washington State University
Access Center
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HOUSING ACCOMMODATION REQUEST
VERIFICATION OF DISABILITY/CHRONIC HEALTH CONDITION

The student named below has applied for consideration to be approved for **HOUSING ACCOMMODATIONS** in the student's place of residence. In order to determine eligibility, we require documentation of the student's disabling health condition as it relates to living in the residence halls. This documentation could address permanent disabilities, chronic diseases or illnesses, and mental or emotional conditions.

Documentation must indicate "a physical or mental impairment that substantially limits one or more major life activities," including the ability to function in a postsecondary academic environment. Documentation must provide information about how the patient's functioning is limited, and substantiate the patient's request. To facilitate a prompt review and help to avoid additional requests for documentation, please complete all questions. Failure to do so may result in delay or denial of a request.

INFORMATION RE: EMOTIONAL SUPPORT ANIMAL REQUESTS:

Federal law (Fair Housing Act) allows individuals with disabilities the presence of emotional support animals in University housing. By law, an emotional support animal is defined as an animal needed for emotional support. An individual may keep an emotional support animal as an accommodation in University housing if:

1. The individual is disabled, or has a chronic medical condition that impacts a major life function.
2. The individual has presented this completed form or other documentation to the Access Center that describes the functional limitations of the individual's disability. (Under the Fair Housing Act, the request for documentation is allowed.) Documentation must be from a qualified medical provider who has an established relationship with the individual.
3. The animal is necessary to afford the individual an equal opportunity to use and enjoy WSU Housing.
4. There is an identifiable relationship between the impairment and the assistance the animal provides. This is determined through the documentation from a qualified medical provider.

NOTE: WSU CAPS, CHS and the WSU Psychology Clinic DO NOT provide documentation for Emotional Support Animals.

SECTION 1 - To be completed by STUDENT

Name (First and Last)

ID Number

Date of Birth (MM/DD/YYYY)

Phone Number

Email Address

Current/Permanent Address

My **signature** authorizes my medical provider to release the following information to WSU:

Please continue to the next page.

SECTION 2 - To be completed by QUALIFIED HEALTHCARE/MENTAL HEALTH PROVIDER

General Description of Condition:

Prognosis/Anticipated Duration:

☐ **Permanent/Chronic**

☐ **Intermittent**

☐ **Temporary, expected to last (days/ weeks/months):**

Date of Diagnosis (MM/DD/YYYY)

Date when patient was last seen for this condition:

Please describe **how the patient's functioning is substantially limited** by his/her medical condition/disability. Please explain how these limitations are caused by the diagnosed condition (including medication side effects), and the **major life activities** affected as they relate to living in University Housing. Major life activities include, but are not limited to: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Please explain how the functional limitations (i.e. symptoms) resulting from the patient's health condition can be reduced or alleviated, and the specific University Housing accommodations needed to do so.

Are there other accommodations in addition to (or in lieu of) an the above listed accommodations that would address the limitations of the student's medical condition, thereby allowing the student to live successfully in University Housing?

Please continue to the next page.

SECTION 3 - To be completed by QUALIFIED HEALTHCARE/MENTAL HEALTH PROVIDER

Please provide your name, title, and professional credentials - including license, certification, or area of specialization, employment, and the state/province and country in which you practice. ***By signing below, you are certifying that you are not a family member of the student/patient named above, the clinical information provided was based on your current and comprehensive evaluation, and you have the professional training, background, and qualifications to provide the foregoing information:***

Printed Name

Signature

Date

Professional Title

License #

Board Certification/Area of Specialization

Name of Organization

Position Title

Street Address

City

State

Zip Code

Phone #

Fax #

This is the end of the form.