



Emotional Support Animal Documentation Form

This form was created in accordance with guidance from the U.S. Department of Housing and Urban Development (HUD) to facilitate an individualized review of a student's request for permission to have an emotional support animal (ESA) residing with them in an on-campus residence hall.¹ Health care providers may instead utilize their own letter or form, but all the information requested herein is typically necessary to establish the disability-related need for an ESA and the reliability of the documentation.

This form should be completed by the physician, psychiatrist, social worker, or other licensed mental health professional who has suggested that having an ESA in the residence hall will have a therapeutic benefit alleviating one or more of the identified symptoms or effects of the student's mental health disability.

As noted by HUD, documentation purchased through websites that sell ESA letters is typically not reliable for determining whether an individual has a disability or disability-related need for an assistance animal because the health care providers lack the necessary personal knowledge to make such determinations. These websites typically obtain information from the individual purchasing documentation via an online questionnaire or brief interview, which likely does not meet the standard of personal knowledge needed to reliably establish the presence of a disability and disability-related need for an ESA.²

Generally, reliable documentation would be provided by a licensed healthcare professional who has personal knowledge of the student as it relates to diagnosis, care, and treatment, consistent with their professional obligations.

The information submitted to SDS should reflect the most current information available. The completed form may be faxed to 865-974-9552 or sent via email at sds@utk.edu. All documentation will be held strictly confidential as a student record.

¹[HUD Guidelines](#)

²[HUD 2019 Letter](#)

Student Disability Services
1534 White Avenue/199 Blount Hall, Knoxville, TN
37996-3107
865-974-6087 (p) 865-974-9552 (f) 865-622-6566 (vrs)
sds.utk.edu

BIG ORANGE. BIG IDEAS.

Date: _____

Student Name: _____

Date of Birth: _____

Type of Animal: _____

Age of Animal: _____

Information about the Student's Disability

1. Does the student have a disability? (*Federal law defines a person with a disability as someone who has a physical or mental impairment that **substantially limits** one or more major life activities, irrespective of diagnosis.*)

Yes _____ No _____

2. Does the student need an ESA to alleviate one or more symptoms of the disability, and not merely as a pet?

Yes _____ No _____

3. Please explain why you are recommending the student be approved to have an ESA in residence on campus, specifically as it relates to disability symptoms.

4. When did you first meet with the student regarding this disability? _____

5. When did you last interact with the student regarding this disability? _____

6. How many times have you met with the student regarding this mental health disability? _____

Information about the Proposed ESA

7. Is the animal named here one that you specifically prescribed as part of treatment for the student, or is it a pet that you believe will have a beneficial effect for the student while in residence on campus?

8. Is there evidence that an ESA has helped this student in the past or currently?

Importance of the ESA to the Student's Well-Being

9. In your opinion, how important is it for the student's well-being that an ESA be in residence on campus?
10. Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing?
11. Do you believe those responsibilities might exacerbate the student's symptoms in any way?

Thank you for taking the time to complete this form. If we need additional information, we may contact you. The named student has signed this form (below), indicating written permission to share additional information with us in support of the request. By signing this form, the healthcare professional certifies that they are an appropriately licensed professional trained in psychiatric, psychological, or neuropsychological assessment. They further affirm that all information provided is in accordance with professional and ethical standards set forth by their licensing entity.

Healthcare Provider Information

Provider Name (Print): _____

Provider Signature: _____

Type of License: _____ Licensure State: _____

License #: _____

Address: _____

Phone: _____ Fax: _____