

## Campus Disability Resource Center

### Employee Emotional Support Animal Verification Form

The completed form should be returned to the ADA/504 Coordinator at Cal Poly Humboldt either in person, via fax or as an attachment to an employee email.

The employee named below may be eligible for reasonable accommodations provided under the Americans with Disabilities Act as amended. To provide services, Cal Poly Humboldt must have a disability diagnosis. This information will remain confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA), public law 104-191.

#### Section 1: Employee Information (To be completed by employee)

I authorize the release of information requested on this Employee Emotional Support Animal (ESA) Verification Form to the ADA/504 Coordinator or their designee at Cal Poly Humboldt. **This release is valid for one year from today's date or unless otherwise revoked.**

\* Indicates required field

Name: \* Humboldt ID#: \*

Address: \* City: \* State: \* Zip Code: \*

Phone Number: \* Humboldt email: \*

Employee Acknowledgment: \*

I confirm that the practitioner below is an individual from whom I have received therapeutic or medical services for at least the past 30 days. \*

I further understand that this is a process which includes an appointment with the ADA/504 Coordinator prior to bringing my animal to campus. \*

I acknowledge that bringing my animal to campus without authorization may be in violation of the Animals on Campus Policy P17-08. \*

Employee Signature:

Date: \*



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## REMAINDER OF FORM TO BE COMPLETED BY PRACTITIONER

To assist Cal Poly Humboldt in evaluating the request for an ESA and other services, the following information is required.

### Section 2: Disability Information

The ADA defines a person with a disability as someone who has “a physical or mental impairment that substantially limits one or more major life activities or one or more major bodily functions.”

Diagnosis: \*

Date of initial appointment with employee: \*

Are you providing ongoing treatment? \*                      Yes                      No

If no, who will be providing ongoing treatment?

### Section 3: Information About the Proposed ESA

ESA Name: \*

Type of Animal: \*

Age of Animal: \*

Please describe how you determined that this specific animal or species provides relief of symptoms brought on by the employee’s disability (as diagnosed on this form). \*

### Section 4: Licensed Practitioner Information

Name: \*

License Number: \*

Type of License: \*

Address: \*

City: \*

State: \*

Zip Code: \*

Phone Number: \*

Fax Number: \*

Provider Signature: \*

Date: \*

**\*\* This form will not be accepted without signature from practitioner \*\***