



Office of Accessibility and Accommodations
Eastern Illinois University
600 Lincoln Ave
Charleston, IL 61920
217-581-6583

REQUEST FOR INFORMATION

Emotional Support Animal

(The health care provider need not use this specific form, but all the information requested here is necessary for the institution to have in order to consider the request for an ESA; the form is provided as a convenience. This form should be completed in full by the provider and not by the student.)

STUDENT: please sign this form before giving it to your mental health provider to complete.

By signing below, I consent to allowing my health care provider to share any information relevant to my need for an ESA as an accommodation, as shown on this form, with personnel from the OAA for the next 60 days.

Student's Signature

Date

Student's Name: _____ Student's E#: _____

The remainder of this form MUST be completed by a relevant certified health care provider who is recommending that the student requires an ESA as part of an ongoing mental health treatment plan.

The above-named student has indicated that you are the health care provider who has suggested that having an Emotional Support Animal (ESA) in the residence hall will have therapeutic benefit in alleviating one or more of the identified symptoms or effects of the student's mental health disability. Generally, we accept documentation from providers in the State of Illinois or the student's home state who have personal knowledge of the student, consistent with their professional obligations. So that we may better evaluate the request for this accommodation, please answer the following questions.

Information About the Student's 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. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation). What is the nature of the student's mental health impairment (that is, how is the student ***substantially limited***?

Documentation of disability must come from a source with sufficient direct personal knowledge of the individual to clarify the need for the ESA and the nexus between the disability and the presence of the animal in housing.

When did you first meet with the student regarding this mental health diagnosis?

What is the nature of your meetings (i.e., face-to-face meetings or virtual interaction)? _____

When did you last interact with the student regarding this mental health diagnosis?

How often have you seen the student (or plan to see the student) for further counseling/treatment? _____

What specific symptoms is this student experiencing, and how will those symptoms be mitigated by the presence of the ESA? General assessments are typically insufficient. For example, a statement that "The animal alleviates anxiety" is too general and does not explain HOW the animal may alleviate the symptoms of this student's disability. _____

Information About the Proposed ESA

(**Note:** there are some restrictions on the kind of animal that can be approved for the residence hall; it is possible the student may be approved for an ESA, based on the information you provide here, but may not be allowed to bring the specific animal named.)

Proposed ESA (if identified):

Name: _____

Type of animal: _____ Age of animal: _____

Size of the cage/crate needed for containment: _____

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? _____

Dogs and cats are most often requested as ESAs, and seem best suited to adapting to the communal living setting of the college residence hall. If another type of animal is being suggested for this student, please explain why you believe that animal is a better choice. _____

Is there evidence that an ESA has helped this student in the past or currently? If not, why do you believe this may be an effective support for the student now?

Please address the likely impact on the student should the following scenario occur: once the student is living with the animal in the student housing unit, the animal is permanently removed from the unit because of a violation of policy (e.g. the animal injures someone or destroys property) and balance this impact, if any, against the benefit that you expect the animal to provide to the student.

This student was provided with a copy of the rules and restrictions surrounding the presence of an animal in residence in the University housing. Has the student shared those restrictions with you? ☐ Yes ☐ No

Have you and the student discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities and residing in campus housing? ☐ Yes ☐ No

Do you believe those responsibilities might exacerbate the student's symptoms in any way? (If you have not had this conversation with the student, we will discuss with the student at a later date.) _____

Prognosis: Describe the anticipated progression or stability of the disability including any recommendations for future reevaluation.

We recognize that having an ESA in the residence hall can be a real benefit for someone with a significant mental health disorder, but the practical limitations of our housing arrangements make it necessary to carefully consider the impact of the request for an ESA on both the student and the campus community. Thank you for taking the time to complete this form. If we need additional information, we may contact you at a later date. The named student has signed this form (above) indicating written permission to share additional information with us in support of the request.

Please provide contact information, sign and date this questionnaire, and return it to accommodations@eiu.edu or fax to 217-581-7208.

By my signature below, I certify that the information provided above is true and accurate. I confirm I have expertise, history, and knowledge of the student's impairment, which meets the standards of a disability as defined by the ADA, as amended.

Physician/Clinician Name: _____

Medical Specialty: _____

License/Certification #: _____

Address _____

Phone #: _____ Email: _____

Signature: _____ Date: ____/____/____

NOTE: This form has been approved for use as of June 1, 2025. The institution reserves the right to update this form, as appropriate, at any time.