FLORIDA TECH

EMOTIONAL SUPPORT ANIMAL (ESA) REQUEST

STUDENT SECTION

Student Name ______________________________ Student ID # ____________

Student's Campus Address ______________________________

Student's Permanent Street Address ______________________________

City ______________________________ State ________ ZIP ________

Student's Phone ____________________ Student's Email ____________________

ESA Information

Species ____________________ Breed ____________________

ESA Name ____________________ Age of ESA ________ Gender of ESA: ❏ Male ❏ Female

Is the ESA spayed or neutered? ❏ Yes ❏ No ❏ N/A

Is the ESA currently vaccinated and in compliance with the Brevard County licensing requirements? ❏ Yes ❏ No
For more information, visit brevardsheriff.com/home/commands-services/operational-services/animal-services/animal-tags-licenses

Veterinarian Contact Information

Veterinarian's Name/Business Name ______________________________

Veterinarian's Phone # ______________________________

Veterinarian's Street Address ______________________________

City ______________________________ State ________ ZIP ________

Emergency Contact Information

Please provide information for the person who will take responsibility for your ESA should you be unable to care for it due to an emergency. The emergency contact MUST reside OFF CAMPUS and be available to remove the ESA in a TIMELY manner.

Emergency Contact Name ______________________________

Emergency Contact Phone # ______________________________

Emergency Contact Street Address ______________________________

City ______________________________ State ________ ZIP ________

Emergency Contact Email Address ______________________________

Campus Services will require additional procedures to ensure the safety of the animal and the residents if approved for the accommodation. Please initial if you agree to contact Campus Services regarding their procedures for an ESA _______.

Student's Signature ______________________________ Date ____________

Florida Institute of Technology ▪ Office of Accessibility Resources ▪ 150 W. University Blvd., Melbourne, FL 32901-6975 ▪ 321-674-8285 ▪ Fax 321-674-8072

FLORIDA TECH

PROVIDER SECTION

Provider Contact Information

Provider's Name/Business Name ____________________

Phone # ____________________ Fax # ____________________

Street Address ____________________

City ____________________ State __________ ZIP __________

I am the provider of ____________________ (Student's Name) who is requesting to have an emotional support animal (ESA) in the residence hall at Florida Tech.

Professional License # ____________________

Information About the Student's Mental Health Condition

What is the nature of the student's mental health condition? Please include your diagnostic impressions and pertinent background information related to the condition.

How is the student limited by the mental health condition that an ESA would be necessary to reside in campus housing?

Please describe specific symptoms which may be reduced by having an ESA?

What evidence do you have that an ESA has helped the student in the past or present?

To your knowledge, are the parent(s) and/or legal guardian(s) of the student aware of the mental health condition(s) for which you have provided treatment?

❏ Yes ❏ No Explain ____________________

Number of visits provided to the student relating to such condition. ______

List the dates of service ____________________

Florida Institute of Technology ▪ Office of Accessibility Resources ▪ 150 W. University Blvd., Melbourne, FL 32901-6975 ▪ 321-674-8285 ▪ Fax 321-674-8072

As the treatment provider, do you feel the student has completed treatment?

❑ Yes ❑ No Explain ____________________

Do you recommend continued treatment? ❑ Yes ❑ No

If yes, indicate type/course of treatment recommended (i.e., meds, therapy, etc.):

____

If yes, please indicate name, address and phone number of the individual and/or agency you are making the referral to.

Name of Provider ____________________

Street Address ____________________

City ____________________ State __________ ZIP __________

Phone # ____________________ Fax # ____________________

You may wish to refer to and/or consult with the following on-campus treatment providers:

Student Health Center: 321-674-8078 | Student Counseling Center: 321-674-8050

Information about the ESA

Is the ESA identified in the Student Section of this form specifically prescribed as part of your treatment for the student?

❑ Yes ❑ No Explain ____________________

Have you assessed the interaction between the student and their ESA and believe this ESA will have a beneficial impact on the student while in residence on campus?

❑ Yes ❑ No Explain ____________________

In your opinion, how important is it for the student's well-being that the ESA be in residence on campus?

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

List any other recommendations you may have to assist with the student's academic success:

Signature of Treating Provider ____________________ Date __________

For any questions or concerns regarding this form and/or the accommodation process, please contact the Office of Accessibility Resources. Please submit the completed form to:

Rachel Densler, Accessibility Resource Specialist
Office of Accessibility Resources
150 W. University Blvd., Melbourne, FL 32901
Phone: 321-674-8285 | Fax: 321-674-8072 | Email: accessibilityresources@fit.edu