

Assistance Animal Procedure Acknowledgement Form

OWNER INFORMATION

Name: _____ Student ID: _____

Address: _____

Email: _____ Phone: _____

ANIMAL INFORMATION

Service Animal Therapy Animal Emotional Support Animal

Animal's Name: _____ Animal's Weight: _____

Animal Type: _____ Animal's Breed: _____

Sex of Animal: _____ Spay/Neuter Date: ____/____/____

Most recent rabies vaccination date: ____/____/____

Attach copies of vaccination/health records to include in file.

By my signature below, I verify that I have read, understand, and will abide by the guidelines outlined in the Southeast Arkansas College Service and Assistance Animal Policy. I agree to provide the additional information required to complete my request for a reasonable accommodation under the Southeast Arkansas College Service and Assistance Animal Policy. I also agree to allow Southeast Arkansas College to release information relating to the presence of a potential assistance animal to current or prospective roommates and College personnel.

Student's Signature: _____

Printed Name: _____ Date: _____

Disability Services Signature: _____

Printed Name: _____ Date: _____

Verification Form for Assistance Animal Accommodations

I authorize Southeast Arkansas College Housing and Office of Disability Services to receive information from my provider (name) _____. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Southeast Arkansas College personnel on an as needed basis.

Student Signature _____ Date _____

Student Name: _____ **Student ID:** _____

In order to determine reasonable accommodations for housing, Southeast Arkansas College requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider. **The provider completing this form cannot be a relative of the student.** If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).

1. Date of Initial Contact with Student: _____

2. Date of Last Office Visit with Student: _____

Diagnosis: Please list all relevant diagnosis. If applicable, please list all DSM-V or ICD Diagnosis (text and code):

3. Approximate onset of diagnosis: ____/____/____

4. What is the functional impact or limitations of the disability on learning or other major life activity and the degree to which it impacts the individual in the learning context for which accommodations are being requested?

5. Describe the symptoms related to the student's condition that cause significant impairment in major life activity. _____

6. Please state any specific recommendations regarding housing and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the change(s) to the housing environment you recommend are necessary.

7. What species of Service, Therapy, or Emotional Support Animal is necessary for this student?

PROVIDER INFORMATION

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Phone: _____

Please return this form to:
Southeast Arkansas College
Office of Disability Services
1900 Hazel St.
Pine Bluff, AR 71603
Phone: (870) 543-5949
Email: crkline@seark.edu

Assistance Animal Travel and Emergency Plan

It is the sole responsibility of the Owner to care for their assistance animal throughout the duration of their time at Southeast Arkansas College. Assistance animals may not be left in the care of a roommate or other student on campus under any circumstances. As such, students with an assistance animal must have an emergency and travel plan in place to arrange care for their assistance animal in the event that the student themselves is not able to. This plan will be kept on file in both the Office of Disability Services and Housing office so all relevant parties may access this information in the event of an emergency.

Student Name: _____

Assistance Animal Name: _____ Breed: _____

Semester: _____

Student Phone Number: _____

Student Home Address: _____

Assistance Animal's Primary Veterinarian/Office: _____

Veterinary Office Phone Number: _____

If the student is removed from campus due to a medical emergency, or other similar situation, and is unable to take their assistance animal with them, Housing and Disability Services will be notified and the emergency contacts listed below will be asked to retrieve the assistance animal as soon as possible.

Emergency Contact's Name: _____

Emergency Contact's Phone Number: _____

Emergency Contact's Address: _____

Approximate Travel Time for Emergency Contact to Reach SEARK: _____

Emergency Contact's Name: _____

Emergency Contact's Phone Number: _____

Emergency Contact's Address: _____

Approximate Travel Time for Emergency Contact to Reach SEARK: _____

