ΑΣΦ
ALPHA SIGMA PHI
alphasigmaphi.org

SERVICE AND EMOTIONAL SUPPORT ANIMAL REQUEST FORM

Student Name: ______________________________ University: ______________________________

I authorize CLVEN Property Management, LLC to receive information from my primary health care provider, ________________________. I authorize my primary health care provider to discuss my condition(s) with the appropriate and qualified CLVEN Property Management, LLC personnel on an as needed basis.

Student Signature: ______________________________ Date: ____________________________

To determine reasonable accommodations or housing, CLVEN Property Management, LLC requires current and comprehensive documentation of the student's condition from a licensed clinical professional or primary 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 primary health care 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). It is to be filled out by the student's primary professional health care provider within their home state or state of permanent residence where the student was diagnosed and treated.

1. Date of Initial Contact with Student: __________/___________ /___________
2. Date of Last Office Visit with Student: __________/___________ /___________
3. Diagnosis: Please list all relevant diagnoses. If applicable, please list all DSM-IV or ICD Diagnoses (text and code).

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____
____
____

4. Approximate onset of diagnosis: __________/___________ /___________

Severity of symptoms/Prognosis of disorder:
□ mild □ good
□ moderate □ fair
□ severe □ poor

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

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6. Please state the specific recommendation 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.

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Primary Professional Provider Information
By my signature below, I certify 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 #: ______________________________

Address: ____

____

Phone: ___________________________ Email:____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax (317-843-2966) or email (clven@alphasigmaphi.org) to CLVEN Property Management, LLC. All documentation submitted to CLVEN Property Management, LLC is considered confidential.

Adapted with permission from Texas Tech University Student Housing.