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# ESA Verification Form

REQUEST FOR DISABILITY VERIFICATION OF NEED FOR AN  
EMOTIONAL SUPPORT ANIMAL (ESA) FOR PERSONS WITH A  
MENTAL HEALTH DISORDER

Anxiety Disorders, Major Depressive Disorder, Bipolar  
Disorder, Impulse-Control Disorder, etc.

**Form is to be completed by the student's evaluator and then returned to Accessibility Services.**

To ensure the provision of reasonable and appropriate services for students with a mental health disorder who are requesting emotional support animals (aka companion animals), Accessibility Services requires students to provide current documentation of their disability, the need for an emotional support animal, and how the animal will impact their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential.

## Student Information

Student Name: \_\_\_\_\_

1. DSM-5 Diagnosis (ICD-10 Code): \_\_\_\_\_

2. Date of original diagnosis: \_\_\_\_\_

3. How many times have you seen this person? \_\_\_\_\_

4. Emotional Support Animal (ESA) species? \_\_\_\_\_

\_\_\_\_\_

5. Who is the owner of the ESA? \_\_\_\_\_

\_\_\_\_\_



## Evaluator Information

I certify, by my signature below, that I conducted or formally supervised and/or co-signed the diagnostic assessment of the student named above and that I am a licensed psychologist, neuro-psychologist, psychiatrist, or other relevantly trained medical doctor or counseling professional.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

State License(s): \_\_\_\_\_

License Number(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

e-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## For Office Use Only

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Accessibility Services Staff (Full Name): \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date Reviewed/Received: \_\_\_\_\_