

Medical Provider's Information in Support of Request for Emotional Support Animal Approval

Name of Professional completing form: _____

Address, Phone & Email: _____

Name of Patient: _____

They have been under my care since: _____

I am intimately familiar with _____'s history and with the functional limitations imposed by his/her disability. They meet the definition of disability under the Americans with Disabilities Act, the Fair Housing Act, and the Rehabilitation Act of 1973.

Due to disability, _____ has certain limitations. In order to help alleviate these, and to enhance their ability to live independently, I am prescribing an emotional support animal that will assist _____ in coping with their disability.

I possess a valid, active license (*please provide the effective date, license number, jurisdiction, and type of professional license along with this form).

I am licensed to provide professional services within the scope of the license in the jurisdiction in which the documentation is provided. License #: _____

Physician or Clinician signature: _____ | Date: _____