



Assistance Animal Verification Form

The Office of Disability Services
General Technology Building, Room B105
419-559-2200 (Phone)
419-333-8017 (Fax)
DisabilitiesServices@terra.edu

Dear Professional,

The student named on the attached Assistance Animal Verification Form has applied for services available to qualified individuals with disabilities through the Office of Disability Services at Terra State Community College.

Current and comprehensive documentation of the student's disability must be on file in our office to determine appropriate and reasonable housing accommodations. The student identified has indicated that you could provide documentation of disability along with information pertinent to function in a residential living environment and why the requested assistance animal is necessary.

Once the information is received by the college it becomes subject to the Federal Family Education Rights and Privacy Act of 1974 (FERPA) regulations which state that the information is available to the student upon request. Please complete the attached Disability Verification form and return as indicated to our office or to the student.

NOTE TO PROVIDERS:

The information that you provide will **NOT** become part of the student's educational record(s), but it will be kept in the student's file at the Office of Disability Services, where it will be held strictly confidential.



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Student Information

To Be Completed by the Student (Please Print Legibly or Type)

First Name: _____ Last Name: _____
 Date of Birth: _____ Student ID #: _____
 Phone: _____ TSCC Email: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____

I request that the licensed veterinary professional designated below complete this form:

Name of Certified or Licensed Professional: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____

Assistance Animal Information

Animal Type: _____ Animal Age: _____
 Animal Color: _____ Vaccinated: Yes No
 Is the animal house trained: Yes No
 Has the animal ever shown aggression or bitten someone:
 Yes No

Acknowledgement and HIPPA Release

I am requesting to have an assistance animal covered by the Fair Housing Act in my residence in campus housing through the Office of Disability Services at Terra State Community College. I understand that the Disability Services requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability related accommodations and services. Please respond to the following questions as soon as possible. Once complete, please submit the form to the Office of Disability Services.

I authorize the Office of Disability Services to contact the Healthcare Provider listed above, and I give the listed healthcare provider permission to clarify any questions regarding this accommodation request.

Student Signature

Date



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Background Information

To Be Completed by a Certified or Licensed Healthcare Provider

Does the individual identified above have a disability? A disability is a physical or mental impairment that substantially limits one or more major life activities.

Yes No

Describe the nature of your professional relationship with the student (e.g., treating physician, psychologist, clinical counselor, independent expert evaluator, etc.).

When did you first meet with the student regarding their condition or diagnosis?

Explain how the animal does work, performs tasks, provides assistance, and/or provides therapeutic emotional support with respect to the individual's disability.

Is there evidence that an assistance animal has helped this student in the past or currently? Please explain.

Are there specific negative impacts of the individual not having the animal with them? If yes, please explain

Yes No



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Have you discussed the responsibilities associated with properly caring for an animal while engaged in typical college activities? Will these responsibilities exacerbate the student's symptoms?

Yes No

Professional Verification

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider. I certify that I am acting within my clinical scope of practice.

Signature

Date

Printed Name

License Number

Supporting educational, medical and or psychological documentation should be attached and returned to:
*The Office of Disability Services, General Technology Building, Room B105, 2830 Napoleon Rd, Fremont, OH 43420.
419-559-2200 (Phone). 419-333-8017 (Fax). DisabilitiesServices@terra.edu. Please return this form to our office as soon as possible so this student may receive support from our program. If you have any questions, please call 419-559-2200.*