Wayne State University
Assistance Animal Request Form

Name of Student: _______________________________________ Date of Assessment: ___________________

Assessment of qualifying disability must be completed by your health care provider.

Evaluators Name: _______________________________________________________________________

Name of Practice, Address and Phone Number:
____________________________________________________________________________________
____________________________________________________________________________________

Professional Credentials and Designations:
____________________________________________________________________________________
____________________________________________________________________________________

State license number, states in which you are registered and licensed to practice:
____________________________________________________________________________________
____________________________________________________________________________________

Diagnostic statement identifying Student’s disability:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Description of current functional limitations:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Statement on how the animal serves as an accommodation for the verified disability:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Physician Signature: _____________________________________________ Date: ______________________