FINDING OF DISABILITY AND NEED FOR ASSISTANCE ANIMAL

This form is used to make the required finding pursuant to Iowa Code section 216.8C.

TO BE COMPLETED BY PATIENT/CLIENT/REQUESTER

Patient/Client/Requester's Name: _____

Address:_____

Telephone: _____ E-mail: _____

I intend to request that **Iowa State University** permit me to keep an assistance animal as a reasonable accommodation in housing for my disability. In connection with that application, I am requesting that you, my health care provider, complete this form regarding my disability.

_____ _____

Patient/Client/Requester's Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER/ LICENSEE

***Please note: this form must be completed in its entirety. If every item is not answered, the form cannot be accepted and a new form must be completed.**

1. Does your patient/client identified above have a physical or mental condition that substantially limits a major life activity? ☐ Yes ☐ No

2. Does or would an assistance animal alleviate one or more of the symptoms or effects of the condition?

☐ Yes ☐ No

If yes, what particular assistance does the animal provide to your patient/client?

3. As the health care provider/licensee listed below have you:

- Received a separate fee, additional fee, or other form of compensation solely in exchange for making this written finding? ☐ Yes ☐ No
- Had a relationship with the patient/client for at least thirty (30) days? ☐ Yes ☐ No

4. This letter was issued on _____. It will expire after 12 months or at the expiration of the term of your patient/client's rental agreement, whichever is greater.[1]

By signing below, you certify you: 1) have had a relationship with the patient/client for at least thirty (30) days; 2) have met with the patient/client in person or by telemedicine, 3) are sufficiently familiar with the patient/client and their disability, prior to writing the finding, to make the finding; and 4) are legally and professionally qualified to make the finding.

Health Care Provider/Licensee's Name (printed): _____

Health Care Provider Credentials or License Number: _____

Signature: _____

Date:_____

This document may contain privileged and confidential information and/or protected health information intended solely for use by the recipient housing provider. Please exercise care to avoid dissemination.

[1] Unless you as the health care provider/licensee provide a shorter expiration date.

References: Iowa Code sections 216.8B and 216.8C
Resources: https://icrc.iowa.gov/, 515-281-4121, 1-800-457-4416