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 STUDENT/PATIENT/CLIENT/REQUESTER

Student/Patient’s Name:

Address:

Telephone:

Email:

I intend to request that **University of Northern Iowa** permit me to keep an assistance animal as 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.

Student/Patient’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]](#footnote-1)**

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?

1. 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
1. This letter was issued on:

It will expire after 12 months or at the expiration of the term of your student/patient/client rental agreement, whichever is greater.[[2]](#footnote-2)

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 professional 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.**

References: Iowa Code sections 216.8B and 216.8C

Resources: <https://icrc.iowa.gov/> , 515-281-4121, 1-800-457-4416

1. UNI added this language to the original form created by the State of Iowa. [↑](#footnote-ref-1)
2. Unless you as the health care provider/licensee provide a shorter expiration date. [↑](#footnote-ref-2)