



### **Emotional Support Animal Agreement and Release of Information Consent Form**

I have read and understand the Emotional Support Animal Policy and related Procedure and I agree to abide by the requirements applicable to an Emotional Support Animal (ESA). I understand that if I fail to meet the requirements set forth in the policy and related procedure, Redlands has the right to remove the ESA according to Policy and Procedure 524.1:6 and I will nonetheless be required to fulfill any obligations I may have (i.e., housing, academic, employment, or other obligations).

I agree to abide by all policies, Redlands and/or Housing, that are unrelated to my disability, such as assuring the ESA does not unduly interfere with routine activities of the college or housing, or cause difficulties for individuals who reside/work there. Behavior, noise, and odor must not exceed reasonable standards for a well-behaved ESA and these factors must not create unreasonable disruptions to others.

I furthermore give permission to the Disability Coordinator to disclose to others impacted by the presence of my ESA (e.g., Administration, Residence Life Staff, Security, Pest Control, Maintenance, potential and/or actual roommate(s)/neighbor(s), or Supervisor(s)/Co-Worker(s)) that I will have an ESA as an accommodation. I understand that this information will be shared with the intent of preparing for the presence of the ESA and/or resolving any potential issues associated with the presence of the ESA.

I further recognize that the presence of the ESA may be noticed by others on any Redlands-owned property and agree that staff may acknowledge the presence of the animal.

By checking the boxes and including my signature below, I verify that:

- ☐ I have read and understand the policy and related procedure pertaining to an ESA at Redlands and agree to abide by this policy and related procedure.
- ☐ I agree to provide the additional information required to complete my Request for Accommodation under the college's Emotional Support Animal Policy and Related Procedure.
- ☐ I agree to provide my physician or other medical professional with the ESA Provider Request for Health Information form to establish my disability and that an ESA is necessary to use.

Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Disability Coordinator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_