REASONABLE ACCOMMODATION REQUEST MEDICAL SUPPORT FORM

Verification of Disability from Medical Provider

Instructions: You have been named as a medical provider that can provide medical documentation for a reasonable accommodation request.

To Be Filled Out By Tenant:

I, _____ (tenant name), authorize the following medical provider to fill out this form and provide it back to my landlord/ prospective landlord:

_____ (Medical Provider)

_____ _____ _____
Tenant Name Tenant Signature Date

Summary of Request Made by Tenant: _____

_____

To Be Filled Out By Medical Provider

I _____ (name of medical provider) hereby certify that I currently provide medical services for _____ (name of tenant).

The patient named above is disabled pursuant to the definition listed under the Fair Housing Act (FHAct), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) (i.e.: a physical or mental impairment that substantially limits one or more major life activities).

Major life activities include but are not limited to: walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, performing manual tasks and caring for oneself.

Impairments that are considered a disability under the Fair Housing Act include such diseases and conditions as orthopedic, visual, auditory and speech; cerebral palsy, muscular dystrophy, multiple sclerosis, autism, seizure disorder, cancer, heart disease, diabetes, asthma, HIV, mental retardation, mental and emotional illness, drug addiction and alcoholism. Note that these definitions do not cover any individual who is a drug addict and currently using an illegal drug, or an alcoholic who poses a direct threat to property or safety because of their alcohol use.

I certify that this patient has a physical or mental impairment/disability which meets the definition above.

I certify that this condition substantially limits one of more major life activities, has a record of such impairment or is regarded to have such an impairment.

____ Mark if appropriate: I have determined that my patient needs an assistive animal based on healthcare considerations because that animal will perform tasks that will mitigate or alleviate the effects of the disability, provide mobility assistance or alert the individual with a disability or improve the health or well-being by mitigating the disabling condition.

OR

_____ Mark if appropriate: I verify that my patient's request for

_____

is necessary and that the request is directly related to his/her disability and that it is necessary to afford him/her the opportunity to access housing, maintain housing, or fully use/enjoy housing. (Necessary indicates necessity as opposed to only the matter of convenience or preference). I also recommend that this request be approved.

ADDITIONALLY:

___ Mark if appropriate: I verify that my patient's request for more than one service animal is necessary. My patient needs the following service animals and the explanation of what different service or tasks performed by each separate animal is as follows:

_____

_____

_____

I certify that this information is true and correct. Date: _____

Printed Name of Person Filing out this form: _____
Signature: _____
Professional Title: _____
Name of Clinic, Hospital etc._____
Address: _____ Phone Number: _____
Fax Number: _____E-mail: _____

Please return this form to:
Landlord: _____
Address: _____
Fax Number: _____
Email Address: _____

