Disability Verification Form

I have been ___________________________________’s physician, medical professional, and/or
(Name of Patient)

service provider since _____________________________.
(Date)

I am aware that the Fair Housing Act, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act define disability as:

1. A physical or mental impairment which substantially limits one or more of the person’s major life activities, and/or
2. A record of having a physical or mental impairment which substantially limits one or more of the person’s major life activities, and/or
3. Being regarded as having a physical or mental impairment which substantially limits one or more of the person’s major life activities including, but not necessarily limited to: caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

I, _______________________________________, affirm that _________________________________
(Name of Service Provider) **(Name of Patient)**

has a disability as defined above. As a direct result of this disability, it is a medical necessity that his/her reasonable accommodation/modification request for:

____
(Reasonable Accommodation/Modification Details)

be granted to allow for the full use and enjoyment of the premises. Granting this request will alleviate the effects of his/her disability in the following way(s):

____

____

Signature: ___________________________________ **Date**: ________________________________

Name of Service Provider (print): ____

Title: ____

Address: ____

Telephone: __________________ **Fax:** __________________ **Email:** ________________________