Disability Verification Form

Template for Providers

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

health care provider since first day of service, not today's date **.**
(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, service provider, not MA/LPN/RN etc. **, affirm that _____**
(Name of Medical Professional) **(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:

Write request being made to landlord, for example: closer parking space, grab bar in shower, etc.
(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):

Landlord **does not** need diagnostic information; they only need to know how the accommodation above will improve the living situation of your client. Ex: Grab bar will provide stability and reduce fall risk while showering.

Signature: Must be signed by service provider **Date:** Date of service

Name of Medical Professional (print): _____

Title: Title of Medical Professional

Address: Address of Medical Professional, not client home address (can be filled out by office staff)

Telephone: Medical Professional **Fax:** Medical Professional **Email:** Medical Professional