Disability Verification Form

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

health care 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 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:

_____
(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 Medical Professional (print): _____

Title: _____

Address: _____

Telephone: _____ **Fax:** _____ **Email:** _____