**Verification of Disability by Physician or Other Professional for Reasonable Accommodation/Modification Request**

Name of Physician or other professional: _____

Profession: _____

Address

_____

_____

Date_____

Applicant/Resident Name _____

Applicant/Resident Address _____

_____

I herby authorize release of the following information: _____ (Applicant/Resident Signature)

A local housing authority (LHA) may request verification that an applicant/resident has a disability to determine whether the applicant/resident needs a reasonable accommodation in the LHA's rules, policies, practices or services, or needs a reasonable modification of the leased premises or public or common use areas, in order to have equal opportunity to use and enjoy the leased premises or the public or common use areas, or to participate fully in the LHA's programs, activities, or services. The above-named applicant/resident has authorized your release of the requested information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact our office. Thank you for your anticipated cooperation.

Sincerely,

_____

Executive Director and/or Reasonable Accommodation Coordinator

The following proposed reasonable accommodation(s)/reasonable modification(s) to provide the applicant/resident equal opportunity to use and enjoy the LHA's housing, programs, etc. is (are) under consideration by the LHA:

_____

_____

_____

_____

THE FOLLOWING TO BE COMPLETED BY PHYSICIAN (OR OTHER PROFESSIONAL):

1. Based upon your knowledge, does the above-named applicant/resident have a physical or mental impairment which substantially limits one or more major life activities,* or, do you have a record(s) of such an impairment for the above-named applicant/resident? Circle the appropriate answer:

Yes / No

*Note: Determination of whether a physical or mental impairment substantially limits a major life activity is to be made without regard to the ameliorative effects of mitigating measures (e.g., assess substantial limitation of a major life activity, including the operation of a major bodily function, without considering the benefit of medication, assistive devices, etc., to the individual). Furthermore, an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

2. Does the applicant/resident have a disability-related need for the abovementioned reasonable accommodation(s)/ reasonable modification(s) based on the physical or mental impairment? Please explain* your response.

_____

_____

_____

_____

*Note: please only provide information that demonstrates there is a relationship between a disability verified by a "yes" response to question 1 above and the need for the proposed reasonable accommodation/modification. Please do not otherwise provide information as to the nature or severity of the disability.

3. Other comments (please do not provide information that is not directly relevant to the reasonable accommodation(s)/reasonable modification(s)):

_____

_____

_____

CERTIFICATION: I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____ Date:_____

Signature of Physician or Professional

Name:_____ Address:_____

Telephone #: _____