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Verification of Request for Reasonable Accommodation

Date of Request: _____ Name of Person Requesting Accommodation: _____

Description of Accommodation Being Requested: _____

_____

I understand that under federal and state law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. Major life activities include walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, and caring for oneself.

Please explain the nexus that is the connection between the disability and the need for the service animal, as to each animal. For example, how does each of these Chihuahua dogs make it possible for your patient to live in our community? The Federal Fair Housing Law requires that there be a sufficient nexus that causes us to relinquish our ordinary no pet policy or accommodate animals that fall outside the stated pet policy.

Explanation: _____

_____

_____

Impairments also included such diseases and conditions as orthopedic; visual; speech and hearing impairments; Cerebral Palsy; autism; seizure disorder; Muscular Dystrophy; Multiple Sclerosis; cancer; heart disease; diabetes; HIV; mental retardation, mental, and emotional illness; drug addiction; and alcoholism. This definition does 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 alcohol use (224 CFR Part 8.3 and HUD Handbook 4350.3, (Exhibit 2-2).

I certify that _____ has a physical/mental (circle) disability which meets the definition stated above.

I verify that this request is directly related to his/her disability and 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 certify that the information above is true and correct.

Signature: _____ Date: _____

Printed Name: _____ Professional Title: _____

Name of Clinic, Hospital, etc.: _____

Address: _____

Phone Number: _____ Fax Number: _____

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