

VERIFICATION OF DISABILITY FOR REASONABLE ACCOMMODATION

Patient's Name _____

Patient's Address _____

Patient's Phone _____

The person named above has a disability, defined as follows:

A mental or physical impairment that substantially limits one or more major life activities. **Major activities** include, but are not limited to: **caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.**

The mental or physical impairment is:

The **major life activity** substantially limited by a physical or mental impairment is:

In my opinion, allowing _____
Patient's name

to _____
accommodation requested by patient

is a reasonable accommodation of her/his disability and provides her/him with an equal opportunity to use and enjoy her/his housing.

Print Name: _____ Date: _____

Signature: _____
Include title