VERIFICATION OF NEED FOR ACCOMMODATION/MODIFICATION

(To be completed by a third party in a position to know about the person's disability)

Date of Accommodation/Modification Request: _____

Name of Person Requesting Accommodation/Modification: _____

Address: _____

Accommodation/Modification Requested: _____

_____

DEFINITION OF DISABLED

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 an impairment, or is regarded as having such an impairment. Major life activities include, but are not limited to, walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, performing manual tasks, and caring for oneself.

I, _____ , certify that _____ is disabled as defined above. _____'s disability substantially limits one or more major life activities, including, but not limited to, his/her ability to _____

_____

_____

In my professional opinion, _____ may need the accommodation requested in order to have the same opportunity that a non-disabled person has to enjoy his/her housing.

Signature: _____ **Date:** _____

Organization: _____ **Title:** _____

☐ I am the person's treating physician.

☐ I am not the treating physician but I am qualified to verify the person's disability because

_____

_____

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