REASONABLE ACCOMMODATION REQUEST MEDICAL SUPPORT FORM

In accordance with the Housing and Urban Development (HUD) Notice FHEO-2013-01 issued April 25, 2013, people with disabilities may request reasonable accommodations for any assistance animal, including emotional support animals. HUD separates assistance animals into two categories–service animals and support or companion animals, and poses two conditions:

1. Does the person requesting the animal indeed have a diagnosed disability that that impacts major life activities?
2. Does the person requesting the animal have a disability-related need for it and will the animal assist, perform tasks or perform services for the disabled person?

If you answer "yes" to both questions, please complete Part I of this form. Upon receipt, the landlord will forward your signed form for verification to the medical provider named, in accordance with the Fair Housing Act and the Americans with Disabilities Act.

PART I (To Be Filled Out By Applicant/Tenant)

I, (applicant/tenant name)_____ authorize the following medical provider to fill out Part II of this form and return the signed, completed form to my prospective landlord/current landlord:

Medical Provider's Name: _____

Medical Provider's Mailing Address Line 1: _____

Medical Provider's Mailing Address Line 2" _____

Medical Provider's Mailing Address Line 3 State: _____ Zip: _____

Summary of Request Made by Tenant:

_____

_____

_____

_____ _____ _____

Applicant/Tenant Name Applicant/Tenant Signature Date

[PART II ON NEXT PAGE]

PART II (To be sent by Landlord to Licensed Healthcare Professional)

Verification of Disability from Medical Provider

The applicant/tenant named in Part I of this form is requesting accommodation for a disability-related need as noted in Part I of this form. The applicant/tenant has answered "yes" to the two questions posed by HUD as noted on page 1 of this form, and requested you complete Part II and return at the landlord named below at your earliest opportunity. This is a time-sensitive document.

I (name of medical provider) _____ hereby certify that I currently provide medical services for (name of tenant) _____. This patient is disabled pursuant to the definition listed under the Fair Housing Act (FHAct), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) (i.e.: a physical or mental impairment that substantially limits one or more major life activities). Major life activities include but are not limited to: walking, seeing, hearing, speaking, breathing, thinking, communicating, learning, performing manual tasks and caring for oneself.

Impairments that are considered a disability under the Fair Housing Act include such diseases and conditions as orthopedic, visual, auditory and speech; cerebral palsy, muscular dystrophy, multiple sclerosis, autism, seizure disorder, cancer, heart disease, diabetes, asthma, HIV, mental retardation, mental and emotional illness, drug addiction and alcoholism. Note that these definitions do 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 their alcohol use.

I certify that this patient has a physical or mental impairment/disability which meets the definition above.

I certify that this condition substantially limits one of more major life activities, has a record of such impairment or is regarded to have such an impairment.

____ Mark if appropriate: I have determined that my patient needs an assistive animal based on healthcare considerations because that animal will perform tasks that will mitigate or alleviate the effects of the disability, provide mobility assistance or alert the individual with a disability or improve the health or well-being by mitigating the disabling condition.

OR

_____ Mark if appropriate: I verify that my patient's request for:_____ is necessary and that the request is directly related to his/her disability and that it 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 also recommend that this request be approved.

ADDITIONALLY:

___ Mark if appropriate: I verify that my patient's request for more than one service animal is necessary. My patient needs the following service animals and the explanation of what different service or tasks performed by each separate animal is as follows:

_____

_____

I certify that all information is true and correct. Date:_____

Printed name of person completing this form:_____
Signature:_____
Professional Title:_____
Name of Clinic, Hospital etc._____
Address:_____Phone Number:_____
Fax Number:_____E-mail:_____

Healthcare Provide: please return this completed form to: JR Warner Co. LTD, P.O. Box 536, Pleasant Hill, OH 45359
Phone 937-524-5791 or email rentals@jrwarner.com

Thank you for your prompt attention to this matter.