

REASONABLE ACCOMMODATION(S) VERIFICATION

Name: _____

Telephone: _____ E-mail: _____

Address: _____

I authorize _____ to complete the below documentation relating to my physical and/or mental impairment(s) and request for accommodation(s). I agree that only original documentation completed/provided by a certified or licensed professional will be accepted. I understand it is my responsibility to have the below portion completed by a certified or licensed medical professional and to submit it to the ADA/Section 504 Compliance Coordinator.

Requesting Individual's Signature

Date

Verification Form (to be completed by certified or licensed medical professional)

The individual listed above has requested accommodation(s) for their physical or mental impairment(s). To help us evaluate the requested accommodations, we ask that you please provide the following information:

(a) What is the nature of the physical and/or mental impairment(s)?

(b) How will the physical and/or mental impairment(s) substantially limit their major life activity(ies)?

(c) What, if any, accommodations do you recommend be provided to help ensure their equal access and/or full opportunity to participate in our services? For each recommendation, please explain how that accommodation will ameliorate a substantial limitation.

Name: _____ Title: _____

Agency/Hospital: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Signature

Date

CONFIDENTIAL