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 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 his/her 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 his/her physical and/or mental impairment(s)?

_____

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

_____

_____

_____

_____

(c) What, if any, accommodations do you recommend be provided to help ensure his/her 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