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