REQUEST FOR MODIFICATION / ACCOMMODATION VERIFICATION

DATE_____

TO _____

HEALTH CARE PROVIDER'S NAME

_____

HEALTH CARE PROVIDER'S ADDRESS

_____

FROM_____

COMMUNITY ASSOCIATION NAME

_____

COMMUNITY ASSOCIATION ADDRESS

_____

RE: **REQUEST FOR MODIFICATION OR ACCOMMODATION**

MEMBER'S NAME_____

ADDRESS_____

The Requesting Party above has requested a modification to the building and/or an accommodation to our rules, regulations, and services based on the claim that the Requesting Party has the following medical issue which constitutes a disability as defined below (state nature of medical condition/disability*)*: _____

_____

_____

According to the Requesting Party, the disability limits his/her ability to (explain need for modification/accommodation):

_____

_____

_____

Therefore, the Requesting Party has made the following request:

_____

_____

_____

Under federal law, if an individual with disabilities requests a reasonable modification or accommodation to that disability, the Association must consider the request. To do this, the Association must verify that the individual qualifies as disabled under Virginia or federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her home.

We would appreciate your cooperation in answering the questions on this form and returning it to the address listed above.
Enclosed is a stamped, self-addressed envelope for this purpose. The member has consented to this release of information, as shown below.

DEFINITION OF 'DISABLED'
Under federal 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.

The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic,
visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes. Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction, and alcoholism. This definition doesn't include any individual who is a drug addict and is currently using illegal drugs, or an alcoholic who poses a direct threat to property or safety because of alcohol use.

INFORMATION REQUESTED

1. Is member named above disabled as defined above? Yes ❑ No❑

2. In your professional opinion, is the Requesting Party limited in his/her life activity as described above. (If the answer is No, is the Requesting Party's life activity limited some other way?) Yes ❑ No❑ Explain below.

_____

_____

_____

3. If you answered "Yes" to question number 1, can the member's condition be otherwise treated to prevent any substantial limits in any of his/her major life activities? Yes ❑ No❑

NAME & TITLE OF PERSON SUPPLYING INFORMATION _____

FIRM/ORGANIZATION_____

Would you be willing to testify in any court action or related proceeding as to member's need for the requested accommodation?
Yes ❑ No ❑

HEALTH CARE PROVIDER'S SIGNATURE _____

MEDICAL LICENSE # (IF PHYSICIAN)_____DATE _____

RELEASE

TO THE MEMBER:

YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE COMMUNITY ASSOCIATION OR THE HEALTH CARE PROVIDER IS LEFT BLANK.

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the community association named above to verify information that is up to five years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

SIGNATURE_____DATE _____