



**REQUEST FOR REASONABLE ACCOMMODATION(S)**

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: \_\_\_\_\_

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