Request for Reasonable Accommodation

To be completed by resident

Name: ____ Date: ________________

Address: ____

Phone: (________) _________________________ Cell: (________) ____________________

The above-named person is currently residing in or applying for admission to public housing and has expressed need for a unit with special features, a live-in aide, or another type of reasonable accommodation. The resident/applicant has named you as their physician who can verify the need for requested accommodation(s) or aide. Please review the information provided and confirm with written medical documentation the need for listed characteristics.

To Be Completed by Physician

Name of resident needing reasonable accommodation: ______________________________

Reasonable Need

☐ Barrier-free Apartment ☐ Extra Bedroom ☐ Live-in Aide

☐ Hearing Impaired Unit ☐ Vision Impaired Unit ☐ Unit Modifications

Please list the type of unit modifications or equipment for extra bedroom(s):

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Explanation of Reasonable Accommodation Need: ______________________________________

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Name & Title of Person Providing Information: ____

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Agency Name & Address: ____

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Phone Number: (______) __________________

I, Dr.__________________________________, do hereby certify that all information so given is true and correct to the best of my knowledge. I also acknowledge that falsely submitted information can possibly result in the loss of my license to practice. I further understand that, if the reasonable accommodation is approved, my certification given here will be used to justify the expense of federal dollars by the housing authority.

So sworn this ____________ day of ________________________ 20______________.

___________________________________ ______________________________

Physician Signature License Number