**Reasonable Accommodation Request Forms**

REASONABLE ACCOMMODATION REQUEST FORM

(To be submitted by member with signed Medical Information Authorization)

 *The Association will consider all requests for reasonable accommodations due to disability. The Association must verify that the requesting member qualifies as disabled under federal law and requires the requested accommodation in order to have an equal opportunity to enjoy the use of his or her home and the common area and/or limited common area of the Association. Under federal law, an individual is disabled if he or she has a physical or mental impairment; or is regarded as having such an impairment.*

Member’s Name:
Address:

Phone:

 The undersigned member requests that the Association provide a reasonable accommodation as follows:

 *(Please describe the type of accommodation, how it will assist you, and other details, which you believe are relevant to your request)*

 My specific functional limitation is:

 Member’s Signature Date

MEDICAL INFORMATION AUTHORIZATION

(To be provided to health care provider with Reasonable Accommodation Request – Health Care Provider Verification)

 The undersigned has requested a reasonable accommodation due to disability. Additional medical information is needed to provide the accommodation I have requested. Therefore, I, hereby authorize:

Physician’s Name

Street Address

City/State/Zip

Phone

I hereby authorize the release of medical information pertinent to the accommodation requested on the Reasonable Accommodation Request Form to the Association, its agents, attorneys, and/or representatives. Information obtained under this release shall be limited to information necessary to verify the reasonableness of the request for accommodation, and to information up to five years old.

Member’s Signature Date

REASONABLE ACCOMODATION FOR DISABILITY REQUEST HEALTH CARE PROVIDER VERIFICATION

Health Care Provider:
Address:

Community Association:
Address:

REQUEST FOR ACCOMMODATION:

Member’s Name:
Address:

 The above named member has requested that our community association provide a reasonable accommodation due to disability as follows (*state nature of accommodation request*):

 Under normal circumstances, this request may have been denied pursuant the governing documents of the Association. However, if an individual with disabilities requires a reasonable accommodation to that disability, the Association will consider the request. To aid the Association in considering the request, it must verify that the individual is disabled and requires the accommodation in order to enjoy the use of his or her home and the common elements of the Association. The Association requests that you provide it with the information requested below. A signed copy of the release of medical information is attached for your records, consenting to the release of this information.

 DEFINITION OF “DISABILED”

 *An individual is disabled if he or she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Major life activities include such activities as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working. The term “physical or mental impairment” includes impairments to vision, speech, and mobility, and includes diseases and conditions such as epilepsy, cancer, heart disease, diabetes, HIV infection and alcoholism. This definition does not include an individual who is a drug addict and who is currently using illegal drugs, or an alcoholic who poses a direct threat to the property or safety or others due to alcohol use.*

1. Is the individual named above disabled as defined above? Yes No
2. In your professional opinion, does the individual named above require the requested accommodation in order to have the same opportunity as a non-disabled individual to use and enjoy his or her home and/or the common elements of the Association? Yes No
3. If you answered, “Yes” to Question 1, can the individual’s condition be otherwise treated to prevent any substantial limits on his or her major life activities? Yes No
4. Would you be willing to testify under oath as to the necessity of the requested accommodation? Yes No

Name & Title:

Signature: Date:

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