

Instructions: You have been named as a medical provider that can provide medical documentation for a reasonable accommodation request.

I, _____ (tenant name), authorize the following medical provider to fill out this form and provide it back to my landlord/ prospective landlord:

Medical Provider Name

Date

Tenant Name

Tenant Signature

REASONABLE ACCOMMODATION REQUEST MEDICAL SUPPORT FORM

I, _____, am a qualified medical provider to _____ who is currently my patient.

The patient named above is disabled pursuant to the definition listed under the Fair Housing Act (FHAct), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) (i.e.: a physical or mental impairment that substantially limits one or more major life activities).

I believe that my patient has a disability – related need for an assistance animal (i.e.: the animal provides assistance, performs tasks or services for the benefit of my patient or provides emotional support that alleviates one or more of the identified symptoms or effects of their disability)

Check appropriate box:

- I agree with the statements made above.
- I do not believe my patient meets one or both of the requirements listed in paragraph one or two.
- My patient’s disability requires more than one assistance animal. I am aware of the assistance each animal provides and can attest that each animal provides a difference service/ task.

Medical Provider Name

Date

Signature

Contact Information

Please return this form to:

Property Manager name: **Shawn Hertzog / Kathy Moum**

Company: **KeyIPM.com / West USA**

Email address: **KeyIPM@gmail.com**

Fax number: **Email Only**