

Medical-Necessity Form

_____ (hereafter "Applicant") has requested an accommodation to the policies and procedures of his/her housing provider or housing association. Applicant has requested the following modifications and/or accommodations to either the dwelling or other parts of the housing community and/or to policies, procedures, services or regulations: _____

In order to consider whether the request is reasonable, it is necessary that we have the following information from you as the physician who treats Applicant.

The Florida and Federal Fair Housing Acts define "disability" with respect to a person as a physical or mental impairment that substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment includes:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine.
2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. 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 (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

1. Are you the Applicant's treating medical professional with knowledge of Applicant's medical condition and history? Yes No
2. Does the Applicant have a physical or mental impairment as described above? Yes No
3. What is the expected duration of the impairment? Permanent Temporary
4. Does the impairment substantially limit one or more of the Applicant's major life activities? Yes No
5. In your professional, medical opinion, is the above-described modification or accommodation necessary, in order for Applicant to have an equal opportunity to use and enjoy a dwelling as a person without a disability? Yes No

I swear under penalty of perjury that the above statements are true.

Signature of Medical Professional

Area(s) of Specialty

Printed Name and Title

Date

Name of Practice: _____

Street Address: _____

City: _____ ST: _____ ZIP: _____