LAS BRISAS AT DORAL CONDOMINIUM ASSOCIATION, INC.
REASONABLE ACCOMODATION REQUEST VERIFICATION

Date: _____

To: _____
(Health Care Provider's Name)

_____
(Health Care Provider's Address)

From: **Las Brisas at Doral Condominium Association, Inc.**
5749 NW 115 Court
Doral, FL 33178

RE: REQUEST FOR ACCOMMODATION

NAME OF PERSON REQUESTING THE REASONABLE ACCOMMODATION:

_____ ("Applicant")
_____
Doral, FL 33178

The Applicant named above has requested that the Association accommodate his/her disability by allowing him/her to maintain a _____ within his/her Unit that _____. Section 17.11 of the Association's Declaration of Condominium of Las Brisas at Doral Condominium No 8 ("Declaration") entitled "Pets" provides,

Tenants shall not be permitted to keep or have pets of any kind.

Under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests a reasonable accommodation due to that disability, we must consider the request. To do this, we must verify that the individual qualifies under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her home.

We would appreciate your cooperation in answering the questions on this form and returning it to the Association's address listed above. The Applicant has consented to this release of information as shown below.

INFORMATION REQUESTED

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 impairement as described below? _____ Yes _____No

3. What is the expected duration of the impairement? _____Permanent _____Temporary

4. Does the impairement substantially limit one or more of the Applicant's major life functions or activities?
_____ Yes _____ No

5. If yes, please indicate which major life functions or activites are affected and describe how it affects the Applicant.

6. In your professional opinion, does the Applicant need the accommodation requested in order to have the same opportunity that a non-disabled individual has to use and enjoy the living quarters? _____ Yes _____ No

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7. If yes, please describe how the requested accommodation lessens the effects of the Applicant's disability or facilitates the Applicant's ability to function. _____
_____
_____

DEFINITION OF DISABLED"
Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

The term “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; specific 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 functions or activities means functions such as caring for one’s self, performing manual tasks, walking, lifting, reaching, sitting, sleeping, standing, seeing, hearing, speaking, breathing, concentrating, learning, interacting with others, and

NAME & TITLE OF PERSON SUPPLYING INFORMATION: _____

FIRM/ORGANIZATION: _____

HEALTH CARE PROVIDER'S SIGNATURE: _____

MEDICAL LICENSE NO. (IF PHYSICIAN) _____ DATE: _____

RELEASE

TO THE APPLICANT:

RELEASE: I hereby authorize the release of the requested information. The information obtained under this consent is limited to information that is no older than twelve (12) months. There are circumstances that would require the Association named above to verify information that is up to five (5) years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

SIGNATURE: _____

DATE: _____