CERTIFICATION OF NEED FOR A REASONABLE ACCOMMODATION/MODIFICATION

NATICK GREEN CONDOMINIUM

Please note health care providers are not required to fill out this form, however this form was created to assist providers in providing the type of information the Association/Condominium will need in order to determine whether an individual patient qualifies for an accommodation allowing them to maintain either a service, other assistance animal or a modification. In the alternative providers may provide the information requested in another format, such as a letter if preferred.

RESIDENT or APPLICANT NAME:____
ADDRESS: ____
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1. My name, address, and business telephone number are as follows (information of qualified professional who is completing this form):

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2. I am a duly licensed physician or medical professional in the State of ______________________and my license number is: __________________.

3. I am certified in the following medical specialty(ies), if any:

   ____.

4. I have or am currently treating the applicant and have personal knowledge of the individual and their disability.

   ☐YES ☐ NO

Please complete the following information as it applies to the above-named resident or applicant:

The Fair Housing Act defines a "person with a disability" to include (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with a record of such an impairment.

5. I am familiar with the resident or applicant's history and with the functional limitations imposed by his disability.

☐YES ☐ NO

6. In my considered professional opinion, the resident or applicant meets the definition of a person with a disability under the Fair Housing Act i.e. limits one or more major life activities.

☐YES ☐ NO

7. If you have answered YES to Numbers 5 and 6 above please verify that the patient has a physical or mental impairment.

☐YES ☐ NO

8. Please describe how the resident/applicant's disability substantially limits one or more major life activities.

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9. Please describe the needed accommodation. If the accommodation includes a recommendation of either an assistance animal (Service or Support Animal) please verify that the patient needs the animal(s) because it does work, provides assistance, or performs at least one task that benefits the patient because of his or her disability, or because it provides therapeutic emotional support to alleviate a symptom or effect of the disability of the patient/client, such that it is not merely a pet.

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10. *Please identify the type of animal(s) being prescribed. For example, identify if the patient/client needs either a dog, cat, small bird, rabbit, hamster, gerbil, other rodent, fish, turtle, or other small, domesticated animal that is traditionally kept in households.

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11. If you are prescribing a "unique animal," other than one of the animals listed in number 10 above, please verify why you are prescribing a unique animal not traditionally kept in households, for example is the animal individually trained to do work or perform tasks that cannot be performed by an animal traditionally kept in households? Do allergies prevent the person form using say a dog or other common household animal? Please verify that without the unique animal (identify the animal) the symptoms or effects of the person's disability will be significantly increased.

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12. Please describe and show the relationship between the residents/applicant's disability and the need for the requested accommodation/modification.

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13. Are there any other alternative methods, procedures, medications, etc. that you can suggest to address this matter?

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14. I understand that this information is solely for the use of the above-named Condominium Trust or Association in evaluating a request for accommodation made by the resident/applicant, that it will be kept confidential and will be provided only to authorized representatives of the above-named Condominium Trust who periodically may need to verify and re-validate that this information is still correct and/or a tribunal of competent jurisdiction should a dispute arise in regards to this request and a complaint is filed by the resident or applicant against the Condominium Trust in regard hereto.

Please initial/check the applicable statement(s) below:

I do not believe the resident/applicant requires a change to the rules, regulations, policies and/or procedures as a result of his/her disability to have an equal housing opportunity.

[ ]

I verify that the above request for a change to the rules, regulations, policies and procedures is necessary for the above-named person, as a result of his/her disability, to have an equal housing opportunity.

[ ]

I cannot verify that the above request for a change to the rules, regulations, policies and procedures are necessary for the above-named person, as a result of his/her disability, to have an equal housing opportunity.

[ ]

Signature____ Date____________________

Title of Provider or other Medical Professional ___________________________________

Phone number: ____

The Association may call the professional who completed this form to verify its authenticity.