

Patient/Resident Name(s): _____

Address: _____

The undersigned certified person is qualified to diagnose the Patient/Resident's disability based on the following qualifications or experience:

The Patient/Resident named above is under my care and I have diagnosed the Patient/Resident with a disability as defined by applicable fair housing laws. Based on the Patient/Resident's disability, I have recommended accommodation of that disability as follows:

Anticipated duration of the disability (check one):

Permanent – condition is expected to exist indefinitely without improvement and there is a continual need for said accommodation.

Temporary – the need for the accommodation is expected to cease no later than (date) _____. If the condition continues beyond the date set forth above, a new Verification of Disability must be submitted.

Acknowledgment

Qualified Provider: _____ Signature: _____ Date: _____

Address: _____

Phone #: _____

The landlord must accept this information in any written format.***If the disability and need for accommodation is known or apparent, or if the accommodation requested is for a service dog trained to perform a specific task related to the disability, the landlord should not request this documentation according to HUD Guidelines.***