RHAWA
Rental Housing Association of WA

DISABILITY VERIFICATION

Patient / Resident Name

Address | Unit # | City | State | Zip

The undersigned is a licensed Medical Doctor or other medical care provider _____(specify) in the state of Washington.

I hereby verify that the patient identified above, resides at the address listed above and has a physical or mental disability and 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

DATED this _____day of _____, 20_____ .
(date) (month) (year)

SIGNATURE | TITLE

Address | City | State | Zip

Phone

This form is not the only version that landlords may require.