SAMPLE
Medical Verification Form

Please note that a letter on professional letterhead from a medical professional is also acceptable. This form is provided as a courtesy.

Date _____

Name _____

Title _____

Address _____

Phone _____ Email _____

- ❑ I certify that _____ has been under my care or has been a client of mine since _____
- ❑ I verify that I have personally provided professional care or treatment to the above named individual.
- ❑ I certify that I am familiar with the above named individual's medical history and disability-related functional limitations.
- ❑ I certify that I am qualified to diagnose or treat this type of disability and that I can attest personally to the diagnosis of this disability and/or disability-related needs.
- ❑ I certify that the above named individual is a person with a disability as defined by the Fair Housing Act. A disability is defined by the Fair Housing Amendments Act (42 USC § 3602 h) as a physical or mental impairment which substantially limits one of more major life activities.
- ❑ I understand that the above named individual is requesting a reasonable accommodation (a change in a rule, policy, practice, or procedure) under the federal Fair Housing Act. They are requesting the following: _____
- ❑ I understand that the above named individual is requesting to make a reasonable modification (physical change) to their rental unit. The physical change that they are requesting is: _____ _____
- ❑ I verify that this reasonable accommodation or modification is necessary in order for the above named individual to be able to have full use and enjoyment of the rental unit.
- ❑ I verify that this reasonable accommodation or modification is necessary for my patient or client for the following reasons: (choose one or more of the following)

  ___ Alleviate disability-related symptoms

  ___ Allow for continued health and stability

  ___ Improve physical, emotional, or psychological function

  ___ Provide mobility support

  ___ Provide essential services

  ___ Enable my patient/client to live more independently

  ___ Other _____

- ❑ I attest that I am available to answer questions you may have concerning this verification and my patient/client's reasonable accommodation or modification request.

Signature _____ Date _____

Licensing or Professional Credentials _____