Request for a Reasonable Accommodation
and
Health Care Provider Certification of Accommodation Need

If you or a member of your household has a disability and needs a reasonable accommodation to have an equal opportunity to use and enjoy the unit, you may request a reasonable accommodation by completing this form. Check all items that apply and provide explanations. Keep copies of all documents for your records.

Name of Tenant or Applicant:

Date: _____

Name of person with disability: _____

Phone Number: _____

Address: 01 Unknown Address
Helena MT 59602

I am requesting the following accommodation/s:

_____

_____

I need this reasonable accommodation because:

_____

_____

If you want your housing provider to speak with someone on your behalf about this request, please provide the following information:

Name: _____

Address: _____

Phone Number: _____

Please notify me within ten working days, in writing, of the Approval or Denial of this Request.

Signature of Tenant or Guest: _____

IMPORTANT: The health care provider certifying the disability and need for a accommodation and/or modification IS NOT required to reveal the specific nature and/or severity of the individual's disability, NOR specific information about treatment. However, there must be an identifiable relationship between the request and the individual's disability.

As a health care provider with the knowledge necessary to make a determination, I am able to advise that qualifies as an individual with a disability, experiencing permanent or long term impacts of an impairment substantially limiting major life activities. The following accommodation or modification is consistent with the needs associated with his/her disability and the expected duration of the disability.

Accommodation/Modification Requested:

_____

_____

Expected Duration of Disability: Lifetime
Specify Length if Not Lifetime:_____

Please describe the major life activities limited by the disability that specifically relate to the need for the request for a reasonable accommodation or modification: Examples: sleeping, learning, eating, walking, seeing, working, talking, caring for one's self, etc.

_____

_____

_____

Please describe how the requested accommodation listed above will ameliorate the limitations of the major life activities referenced above so that an equal opportunity to use and enjoy the premises is available: Example: Dog alerts client to oncoming seizures, allowing time to take medication and reach a safe environment.

_____

_____

_____
Signature of Health Care Provider

_____
Printed Name and Title

Phone Number: _____

Date: _____