THE ISLAND HOUSE APARTMENTS, INC.
REASONABLE ACCOMMODATION REQUEST VERIFICATION

Date:_____

To:_____
Health Care Provider's Name

_____
Health Care Provider's Address

_____
Health Care Provider's Signature

From: The Island House Apartments, Inc.
200 Ocean Lane Drive
Key Biscayne, Florida 33149

RE: REQUEST FOR ACCOMMODATION

NAME OF PERSON REQUESTING REASONABLE ACCOMMODATION:

APPLICANT:
ADDRESS:

The Applicant named above has requested that the Association accommodate his/her disability by allowing him/her to maintain a dog within the apartment he/she occupies that weighs in excess of 25 pounds. In that regard, the Association's House Rules provide, in part, that not more than one (1) pet per apartment is permitted and that this pet is not to exceed 25 pounds.

Under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests a reasonable accommodation due to that disability, we must consider the request. To do this, we must verify that the individual qualifies under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her apartment.

We would appreciate your cooperation in answering the questions on this form and returning it to the Association's address listed above. The Applicant has consented to this release of information as shown below.

INFORMATION REQUESTED

1. Are you the Applicant's treating medical professional with knowledge of Applicant's medical condition and history?

   ☐ Yes ☐ No

2. Does the Applicant have a physical or mental impairment as described below? ☐ Yes ☐ No

3. What is the expected duration of the impairment? ____ Permanent _____Temporary

4. Does the impairment substantially limit one or more of the Applicant's major life functions or activities?

   ☐ Yes ☐ No

5. If yes, please indicate which major life functions or activities are affected and describe how it affects the Applicant.

   _____
   _____
   _____
   _____

6. In your professional opinion, does the Applicant need the accommodation requested in order to have the same opportunity that a non-disabled individual has to use and enjoy her apartment?

   ☐ Yes ☐ No

7. If yes, please describe how the requested accommodation lessens the effects of the Applicant's disability or facilitates the Applicant's ability to function.

_____

_____

DEFINITION OF "DISABLED"
Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

The term "physical or mental impairment" includes:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; specific sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine;

2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

NAME & TITLE OF PERSON SUPPLYING INFORMATION: _____

FIRM/ORGANIZATION:_____

Would you be willing to testify in any court action or related proceeding as to the Applicant's need for the requested accommodation?

□ Yes □ No

HEALTH CARE PROVIDER'S SIGNATURE: _____

MEDICAL LICENSE NO. (IF PHYSICIAN):_____ DATE: _____

RELEASE

TO THE APPLICANT:

RELEASE: I hereby authorize the release of the requested information. The information obtained under this consent is limited to information that is no older than twelve (12) months. There are circumstances that would require the Association named above to verify information that is up to five (5) years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

SIGNATURE:_____ DATE:_____