Northwest Pacific Property Management
4280 Chaney Way SE
Salem, OR 97302
OFC: 503-362-0030 FAX: 503-364-1485

# REASONABLE ACCOMMODATION REQUEST/VERIFICATION

DATE _____ TENANT(S) _____

PROPERTY ADDRESS _____ UNIT # _____

CITY _____ STATE _____ ZIP _____

1. Name of disabled person requesting the accommodation: _____
2. Please describe the accommodation you are requesting: _____

   _____

   _____

3. If reasonable accommodation request is for a service animal, please include a **description** and **photo** of animal:

   _____

   _____

HOUSEHOLD MEMBER RELEASE

RELEASE: I hereby authorize my health care provider, or other Qualified Individual, to provide to my property owner/ agents, all information reasonably requested in connection with this request for a reasonable accommodation. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature _____ Date _____

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 an impairment.
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, and alcoholism. This definition doesn't include any individual who is a drug addict and currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use [ 24 CFR Part 8.3, and HUD Handbook 4350.3, (Exhibit 2-2].

Please return this form to the property owner/ agent:

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Office 503-362-0030 Fax 503-364-1485

EQUAL HOUSING OPPORTUNITY

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HEALTH CARE PROVIDER INFORMATION

To: Qualified Individual (e.g. counselor, social worker, doctor, rehabilitation center, service agency, self-help group, clinics).

The person listed on the other side has requested that his/her property owner/ agent provide the accommodation listed on the other side. The property owner/ agent is required by law to provide reasonable accommodations to disabled persons that will provide them with equal opportunity to use and enjoy their unit and/or common areas. The property owner/ agent does not provide an accommodation when the request is a matter of convenience or preference only.

☐ I have evaluated and/or treated this individual _____ times in the past _____ months/years; or,
☐ I have not seen this individual in the last twelve months.
☐ The last time I evaluated and/or treated him/her was _____

4. Describe how the condition for which you are treating the applicant/tenant limits one or more of your client's major life activities. (Example of major life activities are self care, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Impairments" include physiological, mental, psychological or physical diseases, disorders, or conditions.)

_____

_____

_____

5. Describe how the accommodation that the resident is requesting is necessary to afford him/her the opportunity for full use and enjoyment of the dwelling. Please relate the requested accommodation to the limitation(s) caused by the disabling condition.

_____

_____

_____

I, _____, certify that _____
Name of health care provider (please print) Name of person requesting accommodation

☐ is ☐ is not (please check one) disabled as that term is defined above. I further certify that the requested accommodation
☐ is ☐ is not (please check one) necessary for the person requesting the accommodation to fully enjoy his/her dwelling and/or common areas any non-disabled person would.

_____

_____

_____

I certify that the information provided is true and correct.

Signature _____ Date _____

Printed Name _____ Professional Title _____

Telephone Number _____ Fax Number _____

Address _____

City, State, Zip _____