



Verification of Disability

I, _____ have been working with
(Professional's name- Please Print)

_____ since _____. I
(Patient, Client's Name)

understand that the *Fair Housing Act and Section 504 of the Rehabilitation Act*

defines "**Disability**" as:

1. A physical or mental impairment which substantially limits one or more of the person's major life activities, and/or
2. A record of having a physical or mental impairment which substantially limits one or more of the person's major life activities, and/or
3. Being regarded as having a physical or mental impairment which substantially limits one or more of the person's major life activities.

I also realize that under this definition, a **major life activity** includes, but is not limited to: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working. Understanding this, **I affirm that the above-named patient has a disability which meets this legal definition.**

Additional Comments: _____

Furthermore, **I would be willing to testify under oath that because of the above-named patient's disability, the reasonable accommodation or modification described below is necessary and will affirmatively enhance the above-named patient's quality of life by ameliorating the effects of their disability:**

(Please specify the accommodation needed in relation to the identified disability)

(Signature)

(Date)

(Address)

(Phone)