PUNTA RASSA CONDOMINIUM ASSOCIATION, INC.

MEDICAL RELEASE and REQUEST FOR INFORMATION RELATED TO PATIENT'S REQUEST FOR REASONABLE ACCOMMODATION

TO: (name of health care provider): _____

I, (name of patient/applicant) _____, intend to request that my condominium Board of Directors provide the following accommodation to ameliorate the effects of my disability: [outline requested accommodation here]:

_____
_____
_____

This authorizes you to release the information requested below. Information obtained under this release is limited to information that is no older than 12 months.

Dated: _____ _____
Applicant Signature

DEFINITION OF DISABLED

Under federal and state law, an individual is disabled is he/she has a physical or mental impairment that substantially limits one or more major life activities.

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; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (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.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. 24 CFR §100.201.

NAME AND TITLE OF HEALTH CARE PROVIDER SUPPLYING THE INFORMATION:

_____

FIRM/ORGANIZATION (if applicable) _____

1. How long have you treated the above-named person (Applicant)? _____
2. Is the Applicant disabled as defined above? ___ Yes ___ No
3. What major life activities does the physical/mental impairment substantially limit the Applicant from participating in?
   _____
   _____
4. If the Applicant is an individual with a disability, in your professional opinion, will the requested accommodation ameliorate the effects of the disability?
   ___ Yes ___ No
5. Is the disability and need for the accommodation temporary? ___ Yes ___ No
   If yes, what is the estimated length of need for the accommodation?
   _____
   _____
6. Are you willing to testify in court as to your opinions stated herein?
   ___ Yes ___ No

Signature: _____ Dated: _____

Print Name: _____

License Number and State of Issue: _____