



REASONABLE ACCOMODATION **REQUEST AND VERIFICATION**

NOTICE:

Under law, Tenant(s) have the right to request a change in rules, regulations, practices, or procedures if Tenant(s) have a disability and the requested change will better enable Tenant(s) to use and enjoy the property. Owner/Agent may require Tenant(s) both to document the existence of the disability and to obtain verification from a qualified person who has direct knowledge of the disability (for example, a counselor, doctor, social worker, or rehabilitation center) that the accommodation is related to the disability and would give equal opportunity to use and enjoy the property. If this request follows a Notice of Noncompliance with the terms of a Rental Agreement, Owner/Agent may also ask for documentation to support the claim that the accommodation will better enable compliance with the Agreement. To request such an accommodation, Tenant(s) may fill out the form below, sign and return it to Owner/Agent.

Applicant/Tenant Name: _____

Address: _____

City: _____ State: OR Zip: _____

I/We are requesting a modification of rules, regulations, practices, or procedures for:

(name of person for whom accommodation is requested)

The change I/We are requesting is *(describe what it is you want):*

The name and address of the qualified person providing care for the disabled person (such as a doctor, health care provider, or social worker) who can provide the necessary verification is:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____

I authorize Owner/Agent to contact the above person. I understand that Owner/Agent will be asking for the verifications found on the reverse of this form. I authorize the above-named qualified person to release such information directly to Owner/Agent.

Applicant/Tenant Signature

Date

FROM: J&L Moore Property Management LLC (Owner/Agent)
5247 Teresa Way
Central Point, OR 97502

TO: _____ (Qualified Health Care Provider)

An Applicant, a Tenant or Tenant's family member, has requested (see the other side of this form for Client/Patient's name) a change to rules, regulations, practices, or procedures.

Under Federal Law, someone is **handicapped** or disabled if they *suffer "a physical or mental impairment which substantially limits one or more Major Life Activities,"* or if they have *"a record of such an impairment,"* or are *"regarded as having such an impairment."*

A **physical or mental impairment** means *"(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; genitor-urinary; 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."* Such an 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."*

The term **"major life activities"** means *"functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working."*

Owner/Agent is required under Federal Fair Housing Law to make Reasonable Accommodations when such Accommodation will give someone who is disabled an equal opportunity to use and enjoy the Rental Unit. Owner/Agent is not required to, and will not, approve Accommodations that are a matter of convenience or preference only.

Under penalty of perjury, I attest that this individual is under my care and meets the definition of an individual with a disability, that the requested accommodation is related to the disability, and the requested accommodation is necessary to enable the person equal opportunity to use and enjoy the property.

Qualified Health Care Provider Signature

Date

Printed Name

Professional Title

Organization

Telephone