

## Tell Us About Your Doctor/Physician

<b>Doctor or Clinic Name</b>	<b>Doctor or Clinic Fax #</b>	<b>Doctor or Clinic Phone #</b>
<b>Clinic/Medical Institution Address</b>		
<b>Applicant/Resident Name</b>	<b>Head of Household Name</b>	
<b>Applicant/Resident Social Security #</b>	<b>Applicant/Resident Date of Birth</b>	
<b>Consent to Release Information: My signature below authorizes verification of my disability.</b>		
Applicant/Resident Signature _____		Date _____

**STAFF USE ONLY**

The above Applicant/Resident is applying to/participating in a housing program that requires verification of disability. The individual has signed a release above giving you permission to supply us with information requested. The information provided will remain confidential. Please return the completed form to the address/fax below.

**I certify that this verification has been sent directly to the doctor/medical institution and was not hand-carried by the applicant/tenant or any other interested party.**

Signature of Owner/Agent _____	Title _____	Date _____
Owner/Agent Address _____	Owner/Agent's Fax Number _____	

**This section to be completed by qualified medical staff as defined in U.S. Code: Title 42, 1437a**

The determination of disability status, as defined by Congress, must be based on a professional medical evaluation.

**CERTIFICATION OF AUTHORIZED MEDICAL PERSONNEL AS DEFINED ABOVE**

(Please check only **one** box)

1.  I find this individual has a physical or mental impairment that limits one or more major life functions that has lasted or is expected to last for a continuous period of not less than 12 months.
- OR-
2.  I find this individual does not have a physical or mental impairment that substantially limits one or more major life functions and is expected to last, or has lasted, less than 12 months.

**Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any Department or Agency of the U.S. as to any matter within its jurisdiction.**

Signature of Evaluator/Diagnostician _____	Title _____	Date _____
Print name of Evaluator/Diagnostician _____	Telephone # _____	