Verification of Disability

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

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

I understand that "**Disability**" is defined 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.**

Please specify the accommodation needed in relation to the identified disability: _____

_____

_____

Furthermore, I certify and affirm that the information provided on this form is true and correct to the best of my knowledge and in my professional opinion that 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:

_____ _____
(Signature) (Date)

_____

_____ _____
(Address) (Phone)