ANGLER'S REEF PROPERTY OWNERS' ASSOCIATION, INC.
REASONABLE ACCOMMODATION REQUEST VERIFICATION

Date:_____

To:_____
Health Care Provider's Name

_____
Health Care Provider's Address

_____
Health Care Provider's Signature

From: Angler's Reef Property Owners' Association, Inc.
c/o Harbor Management Services, Inc.
15600 SW 288 Street, Suite 406
Homestead, FL 33090
bill@harbormanagement.us

RE: REQUEST FOR ACCOMMODATION

NAME OF PERSON REQUESTING REASONABLE ACCOMMODATION:

APPLICANT: _____
ADDRESS: _____
_____

The Applicant named above has requested that the Association accommodate his (or her, as appropriate) disability by allowing him (or her, as appropriate) to maintain a dog within the unit he (or she, as appropriate) intends to occupy and to bring the dog within the common areas of the Angler's Reef community. Pursuant to the Association's governing documents, tenants and guests are not permitted to have pets within the community.

Accordingly, under normal circumstances, our policies would require us to deny the request. However, under federal law, if an individual with disabilities requests a reasonable accommodation due to that disability, we must consider the request. To do this, we must verify that the individual qualifies under federal law and requires the accommodation in order to have an equal opportunity to use and enjoy his/her unit.

We would appreciate your cooperation in answering the questions on this form and returning it to the Association's address listed above. The Applicant has consented to this release of information as shown below.

INFORMATION REQUESTED

1. Are you the Applicant's treating medical professional with knowledge of Applicant's medical condition and history?
_____ Yes _____No

2. Does the Applicant have a physical or mental impairment as described below? _____ Yes _____No

3. What is the expected duration of the impairment? _____ Permanent _____ Temporary

4. Does the impairment substantially limit one or more of the Applicant's major life functions or activities?
_____ Yes _____No

5. If yes, please indicate which major life functions or activities are affected and describe how it affects the Applicant.
_____
_____
_____
_____
_____

6. In your professional opinion, does Applicant need the accommodation requested in order to have the same opportunity that a non-disabled individual has to use and enjoy the living quarters? _____ Yes _____No

7. If yes, please describe how the requested accommodation lessens the effects of Applicant's disability or facilitates the Applicant's ability to function. _____
_____
_____

8. If the request is for a service animal, identify the specific activities and functions for which the service animal has been

infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

Major life functions or activities means functions such as caring for one's self, performing manual tasks, walking, lifting, reaching, sitting, sleeping, standing, seeing, hearing, speaking, breathing, concentrating, learning, interacting with others, and working.

STATUTORY PENALTY: IN ACCORDANCE WITH SECTION 413.08(9), FLORIDA STATUTES, A PERSON WHO KNOWINGLY AND WILLFULLY MISREPRESENTS HERSELF OR HIMSELF, THROUGH CONDUCT OR VERBAL OR WRITTEN NOTICE, AS USING A SERVICE ANIMAL AND BEING QUALIFIED TO USE A SERVICE ANIMAL OR AS A TRAINER OF A SERVICE ANIMAL COMMITS A MISDEMEANOR OF THE SECOND DEGREE, PUNISHABLE BY (1) A DEFINITE TERM OF IMPRISONMENT NOT EXCEEDING 60 DAYS AS PROVIDED IN SECTION 775.082, FLORIDA STATUTES OR (2) A FINE OF $500.00 AS SET FORTH IN SECTION 775.083, FLORIDA STATUTES AND SUCH VIOLATOR MUST PERFORM 30 HOURS OF COMMUNITY SERVICE FOR AN ORGANIZATION THAT SERVES INDIVIDUALS WITH DISABILITIES, OR FOR ANOTHER ENTITY OR ORGANIZATION AT THE DISCRETION OF THE COURT, TO BE COMPLETED IN NOT MORE THAN 6 MONTHS.

NAME & TITLE OF PERSON SUPPLYING INFORMATION: _____

FIRM/ORGANIZATION: _____

HEALTH CARE PROVIDER'S SIGNATURE: _____

MEDICAL LICENSE NO. (IF PHYSICIAN): _____ DATE: _____

RELEASE

TO THE APPLICANT:

RELEASE: I hereby authorize the release of the requested information. The information obtained under this consent is limited to information that is no older than twelve (12) months. There are circumstances that would require the Association named above to verify information that is up to five (5) years old, which would be authorized by me on a separate consent, attached to a copy of this consent.

SIGNATURE: _____ DATE: _____