

First Name		
Last Name		
Address		
City/State/Zip		
Home Phone		Cell Phone
Email		
Do you own the residence?	☐ Yes ☐ No	If no, when does the lease expire?
Is the owner aware of your request?	☐ Yes ☐ No	If yes, when?
Is the request for the applicant?	☐ Yes ☐ No	If no, who?
Will there be a cost to the Association?	☐ Yes ☐ No	If yes, how much?
Evnlanation: Please describe the disabili		For request uested accommodation or modification and the
disability-related need for the request.	ity and the requ	dested accommodation of modification and the
Signature		



For Office Use Only

Was the application complete?	☐ Yes ☐ No	If no, was additional information requested?
Confirmation letter sent?	☐ Yes ☐ No	If yes, when?
Was the Board notified?	☐ Yes ☐ No	If no, why?
Turned over to attorney?	☐ Yes ☐ No	If no, why?
BOD meeting & decision?		
Decision letter sent?	☐ Yes ☐ No	If yes, when?
	Appeals Proce	ess (If Applicable)
Appeal letter received?	☐ Yes ☐ No	If yes, when?
Appeal hearing scheduled?	☐ Yes ☐ No	If yes, when?
Association attorney present?	☐ Yes ☐ No	If yes, name?
Final BOD decision?		
Decision letter sent?	☐ Yes ☐ No	If yes, when?
Additional comments/information:		



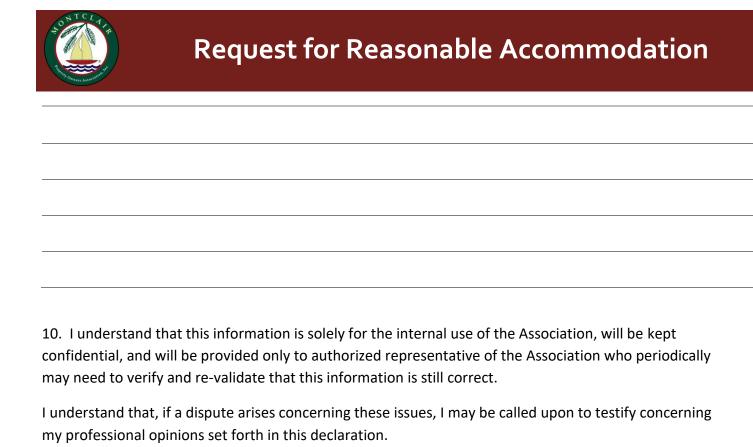
Doctor Confidential Certification Letter					
Fir	st Name				
Last Name					
Address					
City/State/Zip					
Phone		Email			
Date					
	I declare th	at the following statements are true and correct to the best of my knowledge:			
1.		, ("Patient") is my patient whose address is			
2.	. My name, business address, and business telephone number are as follows:				
3.	I am duly lice	ensed in the Commonwealth of Virginia.			
4.	I am also cer	tified in the following medical specialty(ies), if any:			
		air Housing Act defines a person with a disability as one who has "(1) a physical or ent which substantially limits one or more of such person's major life activities, (2) a			

5. The Federal Fair Housing Act defines a person with a disability as one who has "(1) a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) a record of having such an impairment, or (3) being regarded as having such impairment." I hereby certify that Patient has a disability in accordance with the Fair Housing Act due to the following condition or the following reasons:



6.	If you have certified that the Patient is disabled in No. 5 above, can this condition be treated to prevent any substantial limits in any of the Patient's major life activities? Explain any qualifications to your answer.
7.	If your answer to No. 6 above indicates that the condition is treatable, is the Patient's condition being treated to prevent any substantial limits in any of the Patient's major life activities? Explain any qualifications to your answer.

- 8. I am aware that my Patient is requesting an accommodation to rules, regulations, or policies of Montclair Property Owners' Association or is requesting a modification to Association common area or the dwelling that requires Association approval.
- 9. I hereby certify that my patient's request reference in No. 8 above alleviates or mitigates Patient's disability described in No. 5 above or otherwise assists Patient in using and enjoying Patient's home or the common facilities in the MPOA for the following reason(s):



Signature_