Steeplechase of Naples Condominium Association

Medical Certification for Emotional Support Animal
to be completed by health care provider

This person has made a request to keep an assistance/emotional support animal. Persons making such a request under fair housing laws must establish that they are "disabled" within the meaning of those laws and demonstrate that an assistance/emotional support animal is necessary for the disabled person to have an equal opportunity to use and enjoy his or her property. In order to properly evaluate the request, the homeowners association operating the community needs the following information from this person's health care provider.

Patient's Name: _____

Name of physician/practitioner: _____

Address: _____

Telephone number: _____

Email: _____

[The responses to the following inquiries will only be reviewed by the Association's Board of Directors and their management and legal counsel and will not become available for inspection by other residents in the community.]

> FL law was changed in 2020 to require out-of-state providers who complete the ESA form to have provided at least one "in person care or service" to the individual and the provider must have personal knowledge of the person's disability and must be acting within the scope of his or her practice. Proof/documentation that an out-of-state provider has seen the person "in person" at least one time is REQUIRED.

Please describe the patient's physical or mental disability:

Please indicate the major life activity(s) substantially limited by the patient's disability (e.g. sleeping, eating, socializing, walking, talking, hearing, seeing, etc.):

Please describe how allowing the patient to have his/her

_____

(statetype and breed of animal)

as an assistance/emotional support animal accommodates his/her disability and allows him/her to have an equal opportunity to use and enjoy his/her property, and whether and how this would be jeopardized without allowing the animal and if there are other corrective measures which will permit such use and enjoyment:

Please summarize how long you have been evaluating the patient for the above-described impairment, _____ and, if more than two (2) years, how frequently within the last two (2) years, including the last time the patient consulted with you regarding the need for an emotional support animal:

Please provide a summary of your education and/or experience, including specializations or certifications (if any), which qualifies you to make the recommendation for the emotional support animal.

My responses to the above referenced questions are truthful and accurate to the best of my knowledge and belief.

Print Name: _____

Date _____

Signature _____

Disability Verification
Emotional Support Animal

I, (print doctor's name:)
_____
am a licensed physician/health care provider and I have been a treating physician/health care provider treating (print patient's name:)
_____'s disability, since _____, 20____. My license number is _____. I am aware that the *Americans With Disability Act* and *Section 504* of the *Rehabilitation Act* define disability 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.

Major life activities include, but are not limited to: caring for ones' self, performing manual tasks, walking, seeing, hearing, speaking, learning, and/or working. **By signing this document I hereby affirm that the above named patient has a disability which meets the above legal definition.**

MY PATIENT IS SEEKING APPROVAL FOR AN EMOTIONAL SUPPORT ANIMAL PURSUANT TO THE FAIR HOUSING ACT. As an amelioration for the patient's disabling condition, I hereby certify that it is necessary for the patient to have the following reasonable accommodation to enable him/her to live independently and have full use and enjoyment of his/her residence:

_____
_____

I hereby assert that there is no other amelioration for the disabling condition that would be permissible under the community rules, that would permit my patient to live independently and have full use and enjoyment of his/her residence.

_____ _____
Signature of Medical Provider Date

_____
Printed Name of Medical Provider

_____
_____
Address of Medical Provider

_____ _____
Phone Number of Medical Provider Email of Medical Provider

Return all Forms to:

STEEPLECHASE OF NAPLES CONDOMINIUM ASSOCIATION, INC.
c/o Cambridge Property Management of Southwest Florida
2335 Tamiami Trail, Suite 402
Naples, FL 34103
Phone (239) 249-7000