GUARDIAN MANAGEMENT
REASONABLE ACCOMMODATION OR STRUCTURAL MODIFICATION REQUEST FORM

We are committed to the letter and spirit of the Fair Housing Act, which, among other things, prohibits discrimination against persons with disabilities. In accordance with our statutory responsibilities and management policies, we will make reasonable accommodations in our policies, guidelines, practices, or services, when such accommodation is **necessary** to afford persons with disabilities an equal opportunity to use and enjoy their housing communities.

To facilitate timely processing of this request, the person submitting this form, and their Medical Care Provider, should carefully review the information provided to ensure that it answers the questions completely and accurately:

Sections 1 through 2 are to be completed by the person requesting accommodation/modification.

Sections 3 through 7 are to be completed by the Medical Care Provider for the person with the disability.

1. Individual requesting accommodation and/or structural modification. (This is the person who signed or will be signing the lease.) Are you currently a Resident of the apartment community? ☐ YES ☐ NO

Name	Current Address
Phone Number	Email Address
Address of Accommodations/Modification	
2. IF YOU ARE SUBMITING THIS REQUEST FOR SOMEONE OTHER THAN YOURSELF, PLEASE COMPLETE THE FOLLOWING INFORMATION.	
Name	Address
Phone Number	Email Address
Relationship to Resident	

Dear Resident/Applicant – We will attempt to contact the qualified third party professional/health care provider to either request that he/she complete this form and return it to the above community or verify its accuracy. By your signature below, you are consenting for the verifier to release the information needed to complete this form and any follow up information necessary.

Resident’s Signature:

____Date____________________________

SECTIONS 3 – 8 ARE TO BE COMPLETED BY THE REQUESTING PERSON'S MEDICAL CARE PROVIDER (i.e. PHYSICIAN, NURSE PRACTIONER, LICENSED PHYSICIAN'S ASSISTANT OR THERAPIST).

3. Does the person have a disability (a physical or mental impairment) that substantially limits a major life activity? ☐ YES ☐ NO

If you checked Yes, please complete sections 4 – 7. If you checked NO, please skip to Section 7.

4. What is the specific reasonable alteration or modification(s) to Guardian Management's rules, policies, practices, services, and/or building structure that you believe is (are) necessary to accommodate the person's disability?

5. For what duration is the requested accommodation or modification needed? If the requested accommodation or modification is only temporary, please specify the duration needed.

6. Please describe the connection or relationship between the person's disability and the accommodation and/or modification either proposed by you or requested by the person?

7. **MEDICAL PROVIDER COMLETING THIS FORM (check box)**

☐ Physician ☐ Nurse Practitioner

☐ Licensed Physician's Assistant ☐ Therapist ☐ Other: _______________

Printed Name and Title: ____

Phone Number: ____

Signature: ______________________________________ Date: ______________

OFFICE USE ONLY

Request submitted by: ___________________________________ Date: ______________

☐ Applicant ☐ Current Resident

Verified by Medical Provider: Yes _____ No ______ Date: ________________

Reviewed by: ___________________________________ Approved: Yes _____ No ______