Perico Bay Village Association, Inc.

ESA & SERVICE ANIMAL PET REGISTRATION PAGE 1

Re: Request for Medical Opinion (Have your doctor / vet complete the information below)

To Whom It May Concern:

_____ (print name), (herein, "the Patient") has requested that Perico Bay Village Association, Inc. (herein, "the Association") provide **him/her** (circle one) an accommodation to the Association's 40 lbs max pet weight limitation by permitting Patient to keep a _____ lbs (weight) dog _____ (breed) in the unit as a service animal for an asserted disability. The purpose of this letter is to request that you provide your medical opinion as to whether the Patient suffers from a disability **and** whether an accommodation is necessary to reasonably accommodate the asserted disability.

For your convenience, the legal definitions of these terms are provided for your review. Patient has authorized you to provide your medical opinion directly to the Association by signing the authorization found at the end of this letter. The Association requests your cooperation in completing this letter as appropriate and returning it to the Association to the Association's property management company listed at the end.

1. My patient does ____ does not_____ suffer from a handicap, as defined below.

"**Handicap**" means a physical or mental impairment which substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment. This term does not include current, illegal use of or addiction to a controlled substance. For purposes of this definition, an individual shall not be considered to have a handicap solely because that individual is a transvestite. As used in this definition:

"**Physical or mental impairment**" includes:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

"**Major life activities**" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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2. Are you the Patient's treating medical or other professional with personal knowledge of the Patient's medical condition and history?

_____ Yes _____ No

3. If yes, please describe your personal knowledge of the Patient's medical condition and history?

_____

_____

_____

_____

_____

_____

4. if you are a licensed or certified practitioner or provider in a state other than Florida, have you provided in-person care or services on at least one (1) occasion?

_____ Yes _____ No

5. Does the Patient have a "physical or mental impairment" as described above?

_____ Yes _____ No

6. Does the impairment substantially limit one or more of the Patient's "major life activities" as defined above?

_____ Yes _____ No

7. If yes, please describe the impairment and how it affects the Patient's major life activities.

_____

_____

_____

_____

_____

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8. In your professional or medical opinion, is the requested accommodation necessary in order for the Patient to have an equal opportunity to use and enjoy a dwelling as a person without a disability?

_____ Yes _____ No

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

_____

_____

_____

_____

_____

10. Would you be willing to testify in court or other legal proceeding regarding your treatment of the Patient and your medical opinion concerning the Patient's disability?

_____ Yes _____ No

11. If no, please explain why you would not be willing to testify.

_____

_____

_____

_____

12. By providing this supporting information on behalf of Patient, are you acting within the scope of your practice?

_____ Yes _____ No

[INTENTIONALLY LEFT BLANK]

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I assert or swear that the information contained in this letter accurately represents my medical or professional opinion and is true and correct.

Sign Name:_____

Print Name and Title:_____

Dated this _____ day of _____, 20___.

Areas of Specialty:_____

TO WHOM IT MAY CONCERN:

This authorizes the recipient of this letter to provide your medical opinion by completing this letter as you determine appropriate and to provide any further information you deem relevant to the above-referenced Association. A photocopy of this authorization may be relied upon as the original. Your full cooperation is requested.

Sign Name: _____

Print Name: _____

Dated this _____ day of _____, 20___.

RETURN TO: **SUNSTATE ASSOCIATION MANAGEMENT GROUP**
5602 MARQUESAS CIRCLE, SUITE 103
SARASOTA, FL 34233