Bayway Isles - Point Brittany Two Condominium Inc.
5055 Brittany Drive S, St Petersburg, FL 33715
Request/Medical Provider Form

In order for **Bayway Isles - Point Brittany Two Condominium Inc.**, to grant your request to keep a service or emotional support animal in your unit/dwelling within **Bayway Isles - Point Brittany Two Condominium Inc.,** your Association requires you and a medical provider with knowledge about the subject disability and the manner in which an animal can ameliorate the effects of the disability, to complete the below forms. These forms will be kept confidential to the extent required pursuant to the Chapter 718 or Chapter 720 of the Florida Statutes regarding Condominiums and Homeowners Association.

After both you and your medical provider have completed the forms below, **please have your medical provider** return both forms to: **Bayway Isles - Point Brittany Two Condominium Inc. 5055 Brittany Drive S, St Petersburg, FL 33715.**

_____

PART I: TO BE COMPLETED BY RESIDENT

Name: _____ Property Address: _____

Description of Animal (species, breed, weight, color, age, etc.) _____
_____

Description of Limitation: _____
_____
_____
_____

I have had one or more accommodations in the past for my limitation:

_____ Yes _____ No The accommodation was: _____
_____
_____

RELEASE: I hereby authorize the release of the medical information identified in this form to **Bayway Isles - Point Brittany Two Condominium Inc.** and authorize **Bayway Isles - Point Brittany Two Condominium Inc.**, or its agents, to contact the medical provider below and obtain additional information, if necessary, regarding my reasonable accommodation request, authorize the medical provider below to discuss the medical information identified in this form with **Bayway Isles - Point Brittany Two Condominium Inc.** or its agents, and authorize **Bayway Isles - Point Brittany Two Condominium Inc.** to disclose the medical information in this form to the extent allowed pursuant to the Florida Law, Chapter 718 or 720 et seq.

_____ _____
Signature of Resident Requesting an Accommodation Date

PART II: TO BE COMPLETED BY MEDICAL PROFESSIONAL
DISABILITY VERIFICATION
SERVICE/SUPPORT ANIMAL

I, _____ am a licensed physician/health care provider and I have been a treating physician/health care provider treating (Patient's Name): _____ disability, since _____, _____. My license number is: _____. I am familiar with the Federal Fair Housing Act which permits emotional support and service animals. The Act defines a person with a disability to include (1) individuals with physical or mental impairments, (2) individuals who are regarded as having such an impairment, and (3) individuals with a record of such impairment. Under the Federal Fair Housing Act, the **disability must "substantially limit" one or more "major life activities."** The term "major life activity" means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, and speaking. (This list of major life activities is not exhaustive.)

Under normal circumstances, the Association's governing documents would require the Association to prohibit allowing the animal in Bayway Isles - Point Brittany Two Condominium Inc. if such animal was over a certain weight limit. However, under the Federal and Florida Fair Housing Acts, if an individual with a disability requests a reasonable accommodation, including, but not limited to keeping an animal, in violation of the Association's governing documents, the Association must consider the request. To do this, we must verify that the individual qualifies under the Federal and Florida Fair Housing Acts and requires an accommodation in order to have an equal opportunity to use and enjoy his/her dwelling.

Therefore, the Association requests that you respond to all of the following questions:

1. Is above named resident disabled, as defined by the Federal Fair Housing and Florida Fair Housing Acts? _____ Yes _____ No

1a. If yes, please state the disability that substantially limits one or more of the above named resident's major life activities: _____
_____

1b. If yes and you deem appropriate, please attach any additional information to this request and/or provide any other information you deem appropriate regarding his/her disability below:
_____
_____
_____
_____
_____
_____
_____

2. How long have you treated the above named resident for his/her disability?
_____

3. When was the last time you treated the above named resident?
_____

4. In your professional opinion, does the above named resident need the above described animal in order to have equal opportunity to use and enjoy his/her dwelling in _____ **Bayway Isles - Point Brittany Two Condominium Inc.**?
_____ Yes _____ No

Please describe in detail the manner in which the requested accommodation will affirmatively enhance the above-named resident's quality of life by ameliorating the effect of the disability: _____
_____
_____
_____

If the request is granted, will the named resident be able to obey the Association's pet rules that are attached to this form? _____ Yes _____ No
If you marked No, explain in detail why and what variance you recommend:
_____
_____
_____

5. Can the above named resident's disability be otherwise accommodated to have an equal opportunity to use and enjoy his/her dwelling in **Bayway Isles - Point Brittany Two Condominium Inc.** without the animal? _____ Yes _____ No

If Yes, please describe: _____
_____
_____
_____
_____

6. Would you be willing to testify in a proceeding or sign an affidavit as to the above named Resident's need for the requested accommodation? _____ Yes ____ No.

By signing below, I acknowledge and agree that to the best of my knowledge the above information is true and accurate based on my professional medical opinion.

_____ _____
Signature of Medical Professional Date

Print Name: _____
Firm/Organization: _____
Title: _____
License Number: _____
Address: _____
_____
Phone Number: _____