MEDICAL CERTIFICATION FORM
(To be filled out by U. S. Physician – U. S. Medical/Health Professional)

___________________________________ (hereafter "Applicant") has requested an accommodation to the No-Pets policy of the Fincastle Heights Mutual Ownership Corporation . The Applicant has requested the following modification to the Applicant's residence and an accommodation/exception to the Corporation's above-described no-pets policy:

The use of an Emotional Support Animal/Service Animal in the residence.

In order to consider whether the request is reasonable, it is necessary that the Corporation has the following information from you, as the physician/medical professional/therapist who **currently** treats the Applicant.

The federal Fair Housing Act defines "disability" with respect to a person as a physical or mental impairment that substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment.

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.
2. Any mental or physiological disorder, such as mental disability, 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 (HIV) infection, mental disability, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

Major activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. ***(Please check correct Answer.)***

1. Are you the Applicant's treating professional with knowledge of the Applicant's medical condition and history?

   ______ Yes ______No

2. Does the Applicant have a physical or mental impairment as described above?

   ______ Yes ______No

3. What is the expected duration of the impairment?

   ______ Permanent ______Temporary

4. Does the impairment substantially limit one or more of the Applicant's major life activities?

   ______ Yes ______No

   If yes, please indicate which major life activity is affected and describe how it affects the Applicant.

   ____

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5. In your professional opinion, is the above-described accommodation necessary in order for the Applicant to have an equal opportunity to use and enjoy a dwelling as a person without disability?

   ______ Yes ______No

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

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Under penalty of perjury I swear or affirm that the above statement is true to the best of my knowledge.

BEFORE SIGNING THIS DOCUMENT, PLEASE SEE THE IMPORTANT INFORMATION ON THE FOLLOWING PAGE.

____
Signature of Medical/Health Professional

____
Printed Name and Title

Office Address:

____

Office Telephone: ____________________

Date: ______________________________

By signing this document, the Medical/Health Professional certifies that pursuant to Kentucky state law (KRS 383.085(1)(b)), she/he has a current "therapeutic relationship" with the Applicant and is at least one of the following:

1. **A licensed clinical social worker who holds a valid, unrestricted state license under KRS 335.100 and who maintains an active practice within the state;**

2. **A professional counselor who holds a valid, unrestricted state license under KRS 335.525 and who maintains an active practice within the state;**

3. **An advanced practice registered nurse who holds a valid, unrestricted state license under KRS 314.042 and who maintains an active practice with the state;**

4. **A psychologist who holds a valid, unrestricted state license under KRS 319.050 or 319.053 and who maintains an active practice within the state; or**

5. **A physician who holds a valid, unrestricted state license under KRS 311.571 and who maintains an active practice within the state.**