PHYSICIAN CERTIFICATION AS TO NEED FOR SUPPORT/SERVICE ANIMAL

To: CONDOMINIUM ASSOCIATION
(hereinafter, the "Association')

Address: Attention: Management Office
123 Main Street
Ft. Lauderdale, FL 33308

I hereby declare, under penalty of perjury, that the following statements are made from my personal knowledge and are true and correct:

1. _____ (hereinafter referred to as the "Patient") is my patient and have been under my care for approximately _____ months/years.

2. My name, business address, and business telephone number are as follows:

   _____

   _____

   _____

   _____

3. I am a duly licensed physician in the state of _____ and my medical license number is _____.

4. I am also certified in the following medical specialties, if any:

   _____

   _____

5. The Federal Fair Housing Act defines a disabled person as one who has (1) a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) a record of having such impairment, or (3) being regarded as having such impairment. I

hereby certify that Patient is a disabled person pursuant to the above definition from the Fair Housing act due to the following diagnoses:

_____

_____

6. Based upon my education, training, experience and examination of the Patient, I hereby certify that to a reasonable degree of medical certainty, the Patient's disability involves a *substantial limitation* of the major life functions resulting in a long-term impact on the Patient's ability to perform activities that are of central importance to daily life. The major life functions of the Patient that are *substantially limited* by the Patient's disability are as follows:

_____

_____

_____

_____

7. I am aware that the Patient is requesting an accommodation in the enforcement of the Association's covenants, rules, regulations or policies that ordinarily prohibit animals, and that the Patient seeks to reside with a support/service animal. I hereby certify that a service/support animal is necessary to alleviate or mitigate the Patient's disability (described in No. 5 above) or otherwise assist the Patient in using and enjoying the Patient's home or the common facilities in the Association or for the following reasons and/or in the following manners:

_____

_____

_____

_____

8. Are you prescribing a specific breed of animal, or an animal that is already owned by the Patient, to be the service/support animal? If so, please identify said animal:

9. Please identify any special training that the service/support animal you are prescribing required (or already has, if known) in order to be capable of ameliorating the aforementioned substantial limits in the Patient's major life functions:

10. If you are not aware of any special training that the subject service/support animal has (or required) in order to be capable of ameliorating the aforementioned substantial limits in the Patient's major life functions, please explain why this specific animal is necessary and/or whether other animals can capably serve as a service/support animal for this Patient.

11. If you have certified that the Patient is disabled (in No. 5 above), please identify below any alternative treatments or methods to that of prescribing a support/animal that have been attempted in your treatment of the Patient to ameliorate the aforementioned substantial limits in the Patient's major life functions, and whether or not such alternative treatments have been successful:

_____

12. If your response to No. 11 (above) us that no such alternative medical or physical therapies have been attempted, and there is no specific reason why not, please explain:

_____

_____

_____

_____

_____

13. By signing below, I understand that this information is solely for the internal use of the above-named Association, that it will be kept confidential and will be provided only to authorized representatives of the above-named Association who periodically need to verify and re-validate that this information is still correct. I also understand that, if a dispute arises concerning these issues, I may be called upon to testify concerning my professional opinions set forth in this certification.

Physician Signature _____

Printed Name _____

STATE OF FLORIDA)
) ss
COUNTY OF _____)

Subscribed and sworn to before me this _____ day of _____, 20___ by _____, who is personally known to me or presented _____ as identification.

_____
Notary Public, State of Florida