# MEDICAL VERIFICATION FOR ASSISTIVE ANIMAL

Doctor: _____
Address: _____
_____

Patient's Name: _____
Patients Date of Birth: _____
Patients Address: _____
_____
Patient's Phone Number: _____

Request for Doctor to Release Information:

I, _____ (tenant/patient), request that Dr. _____ Immediately release any medical information requested below to the housing facility (owner/agent/property manger) listed below. I further request that the information be delivered to the same.

_____
Tenant/Patient

Medical Information Requested:

Does _____ (tenant/patient) have a physical or mental impairment that substantially limits one or more major life activities that has been documented and diagnosed by you as the treating physician? No Yes
If so, please explain (attach additional sheets, if necessary):

_____
_____
_____
_____

If you classify the tenant/patient listed above as having such a limiting impairment, is it your medical opinion that tenant/patient is in medical need of an assistive animal? No Yes

If yes, what assistance will the animal provide to the tenant/patient?

_____
_____
_____

_____
Doctor License #

PLEASE RETURN COMPLETED VERIFICATION TO:
(This cannot be hand carried by the tenant/patient – please return via USPS or Fax)
Bray Property Management
637 North Ave.
Grand Jct., CO 81501
Fax: (970) 255-3501

Q:/Master Forms/Tenant/Medical Verification For Assistive Animal