Physician’s Disability Certification Form

§ 42-3402.08 of the Rental Housing Conversion and Sale Act of 1980 (D.C. Official Code 2001 ed., as amended, § 42-3401.01 et. seq.) authorizes benefits and restrictions available to those certified by a physician as meeting a specified level of disability.

Tenant’s Name (Please Print) Tenant’s address

To be completed by your physician:

I have examined the above-named person, and I can certify that the person is disabled as defined under the Americans with Disabilities Act of 1990, 42 USC § 12102(2)(A) and 29 CFR § 1630.2(g)(1), and that the disability began on or about ________________________________.

I hereby certify the above information is true and accurate.

Print Physician’s Name & Telephone Number Physician’s Signature DC License Number

Date Physician Signs:

The Mayor shall not disclose information about this person’s disability unless the disclosure is required by law.

THIS FORM IS SUBJECT TO CHANGE ACCORDING TO THE DEFINITION OF PERSONS WITH DISABILITIES ADA CONFORMING AMENDMENT ACT OF 2006, BILL 16-0875.