

**WALSINGHAM APARTMENTS, INC.  
ESA APPLICATION FORM**

In order for the Association to grant your request to keep a service or emotional support animal in your unit within the community, the Association requests that your medical provider with firsthand knowledge of your disability to complete the below form. This form will be kept confidential to the extent required pursuant to the Condominium Act, Chapter 718 of the Florida Statutes.

After your medical provider has completed the form, please return the form to the Association's legal counsel via email, [dan@associationlawfl.com](mailto:dan@associationlawfl.com), or regular mail: Greenberg, Nikoloff, P.A., 1964 Bayshore Blvd., Suite A, Dunedin, FL 34698.

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**TO BE COMPLETED BY MEDICAL PROFESSIONAL**

**DISABILITY VERIFICATION FOR  
SERVICE/SUPPORT ANIMAL ACCOMMODATION**

I, \_\_\_\_\_ am a licensed physician/health care provider and I have been treating (Patient's Name): \_\_\_\_\_ for a disability since \_\_\_\_\_.

My license number is: \_\_\_\_\_. I am familiar with the Florida and Federal Fair Housing Acts which permits individuals with a disability to maintain emotional support and service animals in otherwise pet-restricted housing facilities. 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 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 requested animal to reside within the community. However, under the Florida and Federal 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 Florida and Federal 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 Florida Fair Housing and Federal Fair Housing Acts? \_\_\_\_\_ Yes \_\_\_\_\_ No
  
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. (a) In your professional opinion, does the above-named resident need a service or support animal in order to have equal opportunity to use and enjoy his/her dwelling in Walsingham Apartments, Inc.?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

- (b) In your professional opinion, does the above-named resident need a service or support animal in order to have equal opportunity to use and enjoy the Common Element amenities within Walsingham Apartments, Inc.?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If the request is granted, will the named resident be able to observe reasonable rules that require the animal to be picked up after and kept on a leash while outside the unit/dwelling?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If you marked No, explain in detail why and what variance you recommend:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can the above-named resident's disability be otherwise reasonably accommodated to have an equal opportunity to use and enjoy his/her dwelling and the Common Elements without the animal?                      \_\_\_\_\_ Yes                      \_\_\_\_\_ No

If Yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_