

Application for Members of the Public to Participate Remotely in Public Meeting and Medical Certification of Disability

<u>Applicant Information</u>	<u>Caregiver Information (if Caregiver will attend meeting on behalf of Applicant)</u>
<i>Applicant Full Name</i>	<i>Caregiver Full Name (if applicable)</i>
<i>Applicant Address</i>	<i>Caregiver Address</i>
<i>Applicant Cell Phone Number</i>	<i>Caregiver Cell Phone Number</i>
<i>Applicant Email Address</i>	<i>Caregiver Email Address</i>
<u>Meeting/Agenda Information</u>	
<i>Name, date, and time of meeting</i>	<i>Agenda item that you wish to provide comment</i>

Have you been diagnosed with a disability recognized by the Americans with Disabilities Act?

Are you currently diagnosed with this disability? _____

How does the functional limitation caused by your disability affect your ability to attend the public meeting? _____

I am aware that submitting false or incomplete information on this form may subject me to penalties, including that I may be found ineligible to participate remotely in public meetings.

I hereby designate _____ (name of caregiver, if applicable) to attend on my behalf.

Applicant Signature (or mark if unable to sign)

Date of Signature (mm/dd/yyyy)

Caregiver Signature (if applicable)

Date of Signature (mm/dd/yyyy)

Certification of Medical Professional

1. I, _____ (Medical Professional's Name), am a medical professional and am currently licensed to practice in the United States of America in the field of _____.
2. My address is _____.
3. My office telephone number is _____.
4. I have examined and am familiar with _____
(name of applicant).
5. I confirm that _____ (name of applicant) has a current, clinical diagnosis of a disability that is recognized by the Americans with Disabilities Act.
6. I confirm that this diagnosis would affect the ability of _____
(name of applicant) to attend a public meeting in person.

Signature of Medical Professional

Date of Signature (mm/dd/yyyy)