

**EMOTIONAL SUPPORT ANIMAL REQUEST FORM**  
**North Bay Village Condominium Association, Inc.**

In order for North Bay Village Condominium Association, Inc. (the "Association") to grant your request to keep an emotional support animal in your unit in the North Bay Village Condominium, the Association needs you and a medical provider with knowledge about the subject disability and the manner in which an animal can ameliorate the effects of the disability to provide the proper information needed for the Association to evaluate your reasonable accommodation request. This form is designed to identify that information. If you elect to submit an alternative form, it must comply with the requirements of the Federal and Florida Fair Housing Acts. This form will be kept confidential to the extent required pursuant to Chapter 718 of the Florida Statutes. After both you and your medical provider have filled out the below form, please return the completed form to the Association at:

North Bay Village Condominium Association, Inc.  
c/o Ky Martin, LCAM  
Wise Property Management, Inc.  
18550 N. Dale Mabry Highway  
Lutz, FL 33548  
[kmartin@wisepropertymanagement.com](mailto:kmartin@wisepropertymanagement.com)

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**To be filled out by the resident or tenant requesting an accommodation:**

Name: \_\_\_\_\_

Unit Address: \_\_\_\_\_

Description of Animal (species, breed, weight, color, age, etc.)

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

Under section 413.08 (9), Florida Statutes, a person who knowingly and willfully misrepresents herself or himself, through conduct or verbal or written notice, as using a service animal and being qualified to use a service animal or as a trainer of a service animal commits a misdemeanor of the second degree, punishable with up to 60 days in jail and 30 hours of community service for an organization that serves individuals with disabilities, to be completed in less than six months. Please govern yourself accordingly.

RELEASE: I hereby authorize the release of the medical information identified in this form to the Association, authorize the medical provider below to discuss the medical information identified in this form with the Association or its agents, and authorize the Association to disclose the medical information in this form to the extent allowed pursuant to Chapter 718 of the Florida Statutes.

By signing below, I expressly agree to and do assume personal responsibility for any damage to any property and/or harm to others caused by my emotional support animal. I agree that I shall keep my emotional support animal under my control at all times and will have a leash, harness, or other appropriate and humane restraint at all times, unless my disability prevents such restraint, or the use of such would interfere with my emotional support animal's safe, effective performance of its work or tasks.

THEREFORE I, hereby agree to and do assume all of the risks and responsibilities arising out of my use of and my emotional support animal's presence in North Bay Village Condominium. I also hereby expressly agree to hold harmless, and indemnify the Association and all of its agents, officers, directors, and employees from and against any and all claims, demands, actions, lawsuits or causes of actions, including negligence, that may arise as a result of any acts causing property damage, personal injury or death as a result of my emotional support animal. I further acknowledge that I have been given an opportunity to discuss this release with a legal representative of my choice should I so choose.

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Signature of Resident Requesting an Accommodation

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Date

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**To be filled out by a Medical Professional with knowledge about the subject disability and the manner in which an animal can ameliorate the effects of that disability:**

The resident referenced in pages 1 and 2 has requested that North Bay Village Condominium Association, Inc (the "Association") accommodate his/her disability by allowing him/her to keep the above-described animal.

Under normal circumstances, the Association's governing documents would require the Association to prohibit allowing the animal(s) in the community. However, under the Federal and Florida 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 as disabled under the Federal and Florida Fair Housing Acts and requires an accommodation in order to have an equal opportunity to use and enjoy his/her unit.

Therefore, the Association would appreciate your cooperation by answering the following questions:

1. Is the above-named resident disabled, as defined by the Federal Fair Housing and Florida 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. In your professional opinion, does the above-named resident need the above-described animal in order to have an equal opportunity to use and enjoy his/her unit in the community?

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

If Yes, please explain what unique traits or training the particular animal described above has that another animal that complies with the Association's governing documents would not have: \_\_\_\_\_

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

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5. Can the above named resident's disability be otherwise accommodated to have an equal opportunity to use and enjoy his/her unit in the community without the animal?  
Yes \_\_\_\_\_ No \_\_\_\_\_

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

6. Would you be willing to testify in a proceeding or sign an affidavit as to the above-named Resident's need for the requested accommodation? Yes \_\_\_\_\_ No \_\_\_\_\_

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: \_\_\_\_\_

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