**CITY OF CHANDLER**
**DISABILITY PREFERENCE VERIFICATION FORM**

For purposes of the Disability Preference, an individual with a disability means a person who has a physical or mental impairment which substantially limits one or more major life activities, or has a record of such impairment, or is regarded as having such impairment.

The preference will be applied only upon receipt by the Human Resources Division of this completed and signed Disability Preference Application form. The completed form is intended solely for use in connection with A.R.S. § 38-492. The information is requested on a voluntary basis, will be kept confidential, and will not be shared with the hiring department. The refusal to provide the requested information will not result in any adverse treatment.

Requests for reasonable accommodation in the interview and testing process should be made directly to the Human Resources Division.

Position applied for:_____

Name of Applicant: _____ Phone Number: _____

**To be completed by Applicant's Healthcare Provider:**

**CERTIFICATION OF DISABILITY**

I hereby certify that:

1. The above-named applicant: /__/ is a patient of my practice
/__/ was seen by me on _____ (date).

2. The applicant has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment (as those terms are defined under the Americans with Disabilities Act).

Signature of Healthcare Provider: _____

Name and Title of Healthcare Provider: _____

Address: _____

Phone No: _____

I understand that this document will be reviewed and that I may be asked to provide additional information before the Disability Preference may be applied.

Signature of Applicant:_____ Date:_____/_____/_____

**Return this form directly to:**
City of Chandler, Human Resources Division, P.O. Box 4008, MS 703, Chandler, AZ 85244-4008 or fax under coversheet marked "CONFIDENTIAL" to 480-782-2366.