DOCTOR'S· CONFIDENTIAL CERTIFICATION LETTER

To: Royal Kahili AOAO
76-6283 Ali'I Drive
Kailua Kona, Hawaii 96740

I hereby declare, under penalty of perjury, that the following statements are true and correct to the best of my knowledge:

1. My patient's ("Patient") name and address is:_____
_____

2. My name, business address, and business telephone number are as follows:_____

_____

3. I am a du1y licensed physician* in the State of_____

4. I am also certified in the following medical specialty(ies), if any_____
_____
_____

5. The Federal Fair Housing Act defines a handicapped person as one who has"(1) a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) a record of having such an impairment, or (3) being regarded as having such impairment."
I hereby certify that Patient is a handicapped person pursuant to the above definition from the Fair Housing Act due to the following condition or for the following reasons:
_____
_____
_____

6. I am aware that Patient has requested a waiver of the above Association's recorded covenants, rules, regulations or policies or is requesting a modification in the enforcement of those By Laws, rules, regulations or policies as follows:

Keeping a service/comfort animal in the Patient's unit at the project.

_____

• Or other medical professional, peer support group, non-medical service agency, or other reliable third party who is in a position to know about your disability.

7. I hereby certify that Patient's request alleviates or mitigates Patient's handicap described in No.5 above or otherwise assists Patient in using and enjoying Patient's home in the project or the common facilities, for the following reason(s):

   _____

   _____

8. I understand that this information is solely for the internal use of the above-named Association, that it will be kept confidential and will be provided only to authorized representatives of the above-named Association. I also understand that those representatives may contact me periodically to verify and revalidate that this information is still correct, to confirm that the requested accommodation is still necessary, and to determine whether Patient's disability has been cured.

9. I understand that, if a dispute arises concerning these issues, I may be called upon to testify concerning my professional opinions stated in this declaration.

   I declare under penalty of perjury under the laws of the State of Hawaii that the foregoing statements are true and correct.

   Executed on: _____ ,20___.

_____

_____

Print Name:_____

[Please feel free to attach another page to supplement any responses above]