DOB
DC DEPARTMENT OF BUILDINGS

Government of the District of Columbia

Department of Buildings

Fair Housing Act Request for Reasonable Accommodation

Please read the following information and complete the form below. If you would like or need help to complete this form, please ask for assistance.

The Fair Housing Act 42 U.S.C. §§ 3601-3619 prohibits discrimination in housing on the basis of race, color, religion, sex, national origin, familial status, and disability. This law also requires housing providers and government agencies to make reasonable accommodations or modifications for persons with disabilities.

The District of Columbia will not discriminate against qualified people with disabilities on the basis of disability in the Department of Buildings' (DOB) programs, policies, services and activities. Under the Fair Housing Act (FHA), DOB will, for example:

- Ensure that qualified people with disabilities are not denied access to DOB services, programs, policies and activities on the basis of a disability;
- Reasonably modify DOB rules, policies, programs and procedures to ensure that people with disabilities have equal opportunity to use and enjoy their homes.
- Provide appropriate aids and services leading to effective communication for qualified people with disabilities so they can equally access DOB, programs, and activities. Aids and services include sign language interpreters and other ways of making information and communications accessible to people who have disabilities related to speech, hearing, and vision.

The FHA generally does not require DOB to take any action that would fundamentally alter the nature of DOB programs, services or activities or impose undue financial or administrative burdens on District of Columbia or pose a direct threat to health or safety.

If you have questions, concerns, or complaints regarding the DOB reasonable accommodation process, you may contact the Department of Buildings:

Kathleen Beeton, Zoning Administrator: (202) 705-3304 or Kathleen.beeton@dc.gov

You may also contact the DC Office of Disability Rights:

441 4th St., NW, Suite 729 North, Washington, DC 20001

odr@dc.gov

PHONE: (202) 724-5055 TTY: (202) 727-3363

FAX: (202) 727-9484

Please complete the following information for the person(s) in need of the reasonable accommodation. Feel free to provide additional information if you deem it necessary. In accordance with federal privacy laws, any information that is provided regarding your disability or your reasonable accommodation request to DOB will be treated as strictly confidential unless or until you voluntarily authorize the release of such information in writing. DOB may request additional information that is needed to verify that the individual who is requesting a reasonable accommodation is a qualified person with a disability according to the Fair Housing Act or that the requested reasonable accommodation is needed for the qualified individual with a disability to use or enjoy his or her home. You may be asked to provide documentation regarding your disability such as a letter from your health care provider stating your need for the requested reasonable accommodation:

1. Name of Applicant: ___________________________
2. Name of Person(s) in Need of the Accommodation: ________________________
3. Relationship to the Person(s) in Need of the Accommodation: _____________________________
4. Address of Applicant and Address of Dwelling: ____
5. Address of Person(s) in Need of the Accommodation: ______________________________________
6. Telephone# of Applicant: _______________________________
7. Telephone# of Person(s) in Need of the Accommodation: __________________________
8. E-mail and/or fax: ____
9. Please describe the nature of the disability:

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10. Please describe the requested reasonable accommodation and the building or zoning law (or procedure) from which the accommodation is sought:

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11. Please explain why the reasonable accommodation is necessary:

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I swear under the penalty of perjury that the statements provided herein are truthful and accurate. I acknowledge that false statements to a governmental entity may be a punishable offense.

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Signature of Applicant

If you choose to permit DOB to release your medical information, you may sign the statement below. Your release of medical information is purely voluntary, and your request will be processed regardless of whether you agree to sign the release below.

For Release of Medical Information Only:

I_________________________, knowingly and willingly authorize District of Columbia to release my reasonable accommodation request and any related information regarding my medical history, symptoms, treatment, exam results or diagnosis, for the purpose of disclosing such information to a local or federal governmental agency, or judicial body upon an authorized request.

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Signature of Applicant