13600 Aydell Lane
Walker, LA 70785
(225) 665-4356

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

| Applicant Information | Caregiver Information (if Caregiver will attend meeting on behalf of Applicant) |
|---|---|
| *Applicant Full Name* | *Caregiver Full Name (if applicable)* |
| *Applicant Address* | *Caregiver Address* |
| *Applicant Cell Phone Number* | *Caregiver Cell Phone Number* |
| *Applicant Email Address* | *Caregiver Email Address* |

**Meeting/Agenda Information**

*Name, date, and time of meeting*

*Agenda item that you wish to provide comment*

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)

Email completed form to tammy.payton@walker-la.gov or drop off at City Hall

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## 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)

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