City of Covington
317 N. Jefferson Ave.
Covington, LA 70434
Phone: 985-898-4733

CERTIFICATION OF MEDICAL PROFESSIONAL

MEDICAL PROFESSIONAL

Full Name : _____

Address: _____

Office Phone Number: _____

Verification Email: _____

AFFIDAVITE

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 _____.

I have examined and am familiar with _____ (name of applicant).

I confirm that _____ (name of applicant) has a current, clinical diagnosis of a disability that is recognized by the Americans with Disabilities Act.

I confirm that this diagnosis would affect the ability of _____ (name of applicant) to attend a public meeting in person.

SIGNATURE

_____

SIGNATURE OF MEDICAL PROFESSIONAL Date of Signature

REV: JH01042024