



PENNSYLVANIA LAWYERS FUND FOR CLIENT SECURITY

AMERICANS WITH DISABILITIES ACT ACCOMMODATION (ADA) TITLE II REQUEST FOR REASONABLE ACCOMMODATION FORM
(INCLUDES REQUEST FOR INTERPRETER FOR HEARING /SPEECH IMPAIRED)

Client Information – Section A

Name: _____

Phone: _____

Address: _____

Email: _____

Mobile: _____

Please check the box that most closely describes your status in this matter:

Claimant Attorney Witness

Other (please explain) _____

Requestor Information (if different from above)

Name: _____

Bus. Phone/
Mobile: _____

Address: _____

Fax: _____

Relationship
to Client: _____

Email: _____

TTY: _____

Accommodation

Nature of the disability for which an accommodation is requested: _____

Accommodation requested: _____

Location of Proceeding

Name of Office: _____

Address: _____

Proceeding Information (if known)

File #: _____

Case Name: _____

Proceeding
Date: _____

Proceeding
Time: _____

Proceeding
Type: _____

AFTER COMPLETING THE FORM, PLEASE SEND TO:

Susan L. Erdman, ADA Coordinator, PA Lawyers Fund for Client Security, P.O. Box 62585, Harrisburg, PA 17106

I hereby certify that an Americans with Disabilities Act accommodation is required in the above-captioned action on the date stated.

Signature: _____

Date: _____

FOR OFFICIAL USE ONLY

Service Provider Information - Section B

A SERVICE REQUEST HAS BEEN MADE FOR THE CLIENT NAMED ABOVE.

Service Provider
Company: _____

Fax: _____

Individual
Interpreter Name: _____

Email: _____

Bus. Phone/
Mobile: _____

Date to
Provider: _____

Official Verification – Section C

ADA COORDINATOR SHALL MAINTAIN A COPY IN THE FUND'S CLAIM FILE AND PROVIDE THE ORIGINAL TO THE SERVICE PROVIDER FOR SUBMISSION WITH BILLING.

I hereby verify that the services were performed by the provider in the above-captioned matter on the date and time stated.

Start Date
& Time: _____

End Date
& Time: _____

Official:
(Please print name) _____

Signature: _____

Title: _____

Date: _____