



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

Proceeding Information (if known)

Name of Office: _____ File #: _____
Address: _____ Case Name: _____
Proceeding Date: _____ Proceeding Time: _____
Proceeding Type: _____

AFTER COMPLETING THE FORM, PLEASE SEND TO:
Bethany A. Bryan, 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/ Date to _____
Mobile: _____ 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 _____ End Date _____
& Time: _____ & Time: _____
Official: _____ Signature: _____
(Please print name)
Title: _____ Date: _____

