Office of Minority & Women Business Development
Affidavit of Disability

Instructions: In furtherance of the City of Indianapolis' commitment to economic development and equal opportunity, an individual with a disability may obtain certification of their business as a disability-owned business enterprise (DOBE) for inclusion in the City's Utilization Program.

An applicant for DOBE certification must first demonstrate proof they are an individual with a disability by completing this Affidavit of Disability form. The applicant shall submit the completed form and any supporting documentation to the Office of Minority & Women Business Development (OMWBD) via fax at (317) 327-4482 or by mailing to:

Office of Minority & Women Business Development
Attn: Certification Coordinator
200 East Washington Street, Suite 1701
Indianapolis, Indiana 46204

Upon receipt of the completed Affidavit, the Office of Disability Affairs (ODA) will review the Affidavit and any submitted supporting documentation with legal counsel and make an eligibility determination. After ODA has determined the qualifying member is eligible to apply for DOBE certification, the applicant must then submit a completed Certification Application to OMWBD for its review and final determination. If certification is granted, recertification will be required every three years. As part of the recertification process for DOBEs, a physician form will be required to affirm that the qualifying member continues to be an individual with a disability.

The medical documentation required in this Affidavit is for certification purposes only and will be kept confidential to the extent provided by law.

CONTACT INFORMATION

Name of Company: _____

Address: _____ Suite # _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Contact Person: _____

E-mail Address: _____

DOCUMENTATION OF DISABILITY

In making a determination on whether a person has a disability, OMWBD utilizes the Americans with Disabilities Act (ADA) definition. The ADA defines "disability" with respect to an individual as:

1. A physical or mental impairment that substantially limits one or more of the major life activities of an individual;
2. [Having] a record of such an impairment; or
3. Being regarded as having such an impairment.

42 U.S.C. § 12102

SECTION 1: This Section is to be completed by the business owner/qualifying member with a disability.

Name of Qualifying Member/Owner: _____

Position/Title of Qualifying Member: _____

Which major life activities are substantially limited by the owner/qualifying member's disability? (check all that apply):

_____Physical activities

_____Daily tasks

_____Sensory activities

_____Communication

_____Mental activities

_____Self-care

_____Bodily functions

_____Other (please describe) _____

_____

Describe the qualifying member's disability and identify the limitations it has on major life activities:

_____

_____

_____

_____

_____

_____

_____

_____

BUSINESS OWNER/QUALIFIED MEMBER AFFIDAVIT: I affirm that the statements in Affidavit Section 1 are true, accurate, and complete. I understand that any misrepresentation will constitute as grounds for revocation of DOBE certification.

_____ _____

Signature Date

SECTION 2: This Section must be completed by a physician.

A physician's certification regarding disability is required for each qualifying member with a disability. **This must include a description from the physician certifying the disability on letterhead from their practice, group, or hospital that clearly describes the substantial limitations of the individual with a disability.**

Please note: Section 2 of the Affidavit of Disability form must be completed in its entirety by the treating physician and be accompanied by a description* of the substantial limitations of the declared disability. In addition, the Affidavit and the physician's description must include original signatures.

1. Name of Patient: _____
2. Date of Onset of Disability: _____
3. Diagnosis: _____
4. Date Patient 1st Consulted You: _____

Which best identify the Patient's disability? (check all that apply):

_____Physical/Mobility _____Cognitive

_____Sensory _____Intellectual

_____Neurological _____Communication

_____Chronic Illness _____Mental Health

_____Other (please describe) _____

***REQUIRED** - *Please attach a detailed description of any substantial and continuing limitations resulting from the diagnosed disability that support the individual's self-indication of a disability. The description must be signed by the certifying physician on their letterhead and include the physician's medical license number.*

PHYSICIAN AFFIDAVIT: I certify that I have personal knowledge of all the statements made in Section 2 of this Affidavit and any attachment documentation and that this information is true and correct.

_____ _____
Signature Date

_____ _____
Printed Name of Physician Medical License Number

_____ _____
Practice Name Phone