America's Finest City Softball League
ADA Modification Request From

Please complete this form in conjunction with your physician or other health care provider. When complete, please email the form to ada@afcsl.org prior to the start of the spring season (unless the disability arises after this date).

Player Name (as registered with AFCSL):_____

Physician/Provider Name:_____
Physican/Provider Address:_____
Physician/Provider email:_____
Physician Provider Telephone Number:_____

Please describe the condition requiring and ADA modification (specificity regarding diagnosis, onset, prognosis is helpful when available):_____

_____

_____

_____

_____

Is the modification expected to be needed permanently or temporarily? If temporary, what is the expected duration? _____

_____

_____

_____

Please describe the proposed modification, including how it address the specific disability and helps avoid discrimination and enhance participation: _____

_____

_____

_____

Patient Signature_____ Physician Signature _____

Please feel free to attach any supporting information, especially records of other organizations (e.g., DMV, other sports leagues) who have granted a modification.