

The Villages Reasonable Accommodation Card Application

Name: _____ Address: _____

Phone: _____ Golfer ID # _____

Date Issued: _____ Date Expired: _____

Issued By: _____ Signature: _____

Approved By: _____ Signature: _____

Signature of Applicant: _____

By signing this agreement, I acknowledge the information I have provided from my physician below and/or my placard application properly represents my condition and need for greater access on the golf course that typical protocol allows. I agree to follow the guidelines given to me and am aware they may change from time to time, with or without notification. If they are changed, I will be so advised by the starters. I agree to operate my golf car in a manner causing as little damage and wear to the golf course as possible. I understand that falsification of my condition, abuse of these privileges, or failing to follow the guidelines given to me may result in the suspension of the assigned privileges.

Physician Approval – Physician’s PLEASE READ AND COMPLETE!

In a good faith effort to “do what’s right”, The Villages Golf Management has instituted a policy allowing residents of The Villages who are disabled, or otherwise suffer from a condition that hinders their ability to enjoy a round of golf due to the amount of walking required under typical golf car operation protocol, certain accommodations allowing them to drive their personal golf cars closer to the greens and tees than normal protocol allows. In order to grant this privilege, we are seeking your professional opinion that this individual requires such accommodations. While we will grant this accommodation, without question, to anyone who is disabled under the ADA law, we are willing to extend it to those who need it due to other conditions that do not meet disability requirements. An example of this would be someone who had knee replacement and does not meet the requirements to be considered disabled, but can not make it all the way through a round of golf without some additional accommodation. We trust your medical opinion/ approval will be granted only if you truly believe this accommodation is needed, in light of our good faith effort to accommodate our resident’s needs.

In my professional opinion, _____(Name of Patient) is in need of such accommodation due to the following condition:

Please extend this accommodation through _____(Expiration Date)

Name of Physician: _____ Date: _____

Signature of Physician: _____

THIS FORM MUST BE STAMPED OR FAXED FROM THE PHYSICIAN’S OFFICE (WITH FAX LETTERHEAD). PLEASE FAX TO (352) 751-7720. FOR ANY QUESTIONS, PLEASE CALL THE COUNTRY CLUB ADMINISTRATION LINE (352) 753-3396.