

America's Finest City Softball League
ADA Modification Request Form

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: _____

Physician/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.