

Disability:IN Supplier Diversity

Physician's* Verification of Condition Form

The Standards and Procedures of the Disability:IN Supplier Diversity Program™ enable persons with conditions and/or impairments to have their businesses obtain Disability-Owned Business Enterprise Certification. In order for a firm to become certified, it must first be determined that the owner/applicant is an individual with a specific condition(s) and/or impairment(s) as defined below.

The Disability:IN Supplier Diversity Program™ Standards and Procedures define specific condition(s) and or impairment(s) with respect to an individual, as:

- a. **A physical and/or mental impairment, or condition that substantially limits one or more major life activities of such individual**, and can be demonstrated by appropriate documentation (e.g., records, statements, or other appropriate information) issued by a licensed, registered or certified vocational rehabilitation specialist (i.e., State or private); any Federal agency, State agency, or an agency of the District of Columbia or a U.S. territory that issues or provides disability benefits; or by a licensed medical professional (e.g. a physician* or other medical professional duly certified by a State, the District of Columbia, or a U.S. territory, to practice medicine) who states that the individual is a person with a disability. IEPs (Individual Education Plans) are also acceptable.
- b. **A Service-Disabled Veteran** is a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable, and whose **condition or impairment was incurred or aggravated in line of duty in the active military, naval, or air service**. To be considered a Service-Disabled Veteran, the veteran must have an adjudication letter from the Veterans Administration (VA), a Department of Defense Form 214 (Certificate of Release or Discharge from Active Duty), or a Statement of Service from the National Archives and Records Administration, stating that the veteran has a service- connected disability. Reservists or members of the National Guard who are disabled from a disease or injury incurred or aggravated in the line of duty or while in training status also qualify.

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN OR CERTIFIED LICENSED MEDICAL PROFESSIONAL:

Name of Physician or Certified Licensed Medical Professional
(Printed):

Elizabeth Banovetz, MA, LMFT

Telephone Number: 651-313-8080

Business Address: 1370 Mendota Heights Rd Mendota Heights, MN 55120

Professional Medical License

Number: Licensed Marriage & Family Therapist 3080

Patient Legal Name:

Brett Weaver

Date of Onset of Condition or Impairment:

(MM/DD/YYYY): 11/3/2024 - formally diagnosed w/ADHD - onset of sx: childhood

Describe the Condition(s)/ Impairment(s) (or disability) of the patient and indicate the related functional limitation(s) of the patient below.

Condition, Impairment or Disability:

1. F90.2 ADHD, combined presentation

2. _____

3. _____

Functional/physiological limitations (for example, regularly requires the use of assistive technology to move physically around the community; unable to lift or carry 10 pounds or more; requires assistance for personal needs; etc). Please check all that apply.

☐ Mobility

☐ Communication

☐ Self-Care

☒ Self-Direction

☒ Interpersonal skills

☒ Work Tolerance

☒ Work Skills

☐ Other ways in which the condition, impairment or disability substantially limits major life functions:

Time management, maintaining consistent focus,
organizing work load effectively, navigating relationships
w/co workers, emotional regulation

Do you expect the duration of the indicated limitation(s) to be greater than 3 Years?

☒ Yes

☐ No

If No, please provide a prognosis for recovery?

the patient will need to continue to manage and
cope with ADHD symptoms for the rest of his
life.

I, Elizabeth Banovetz, LMFT, (printed name of physician) certify that the individual patient/applicant named in this document, has the above mentioned condition or impairment as stated. The statements made above and any attached information are true and correct. I understand that submitting and/or attesting to any false information on behalf of an individual applicant could result in the revocation of any falsely acquired Disability:IN™ certification of the above individual applicant and/or could result in legal action against the individual applicant and/or physician in accordance with applicable laws and penal codes.

Signature of Physician or Certified Licensed Medical Professional:

E. Banovetz, LMFT

Date: 10.3.2024

Disability:IN™ CONFIDENTIAL INFORMATION: This document includes confidential information that shall not be duplicated, used, or disclosed -- in whole or in part -- for any purpose other than to evaluate the disability status of an individual seeking certification through the Disability:IN Supplier Diversity Program™.