



## **DISPENSATION CERTIFICATE**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Evening phone: \_\_\_\_\_

Facsimile: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

USEF #: \_\_\_\_\_

Discipline: \_\_\_\_\_

Grade and Profile # (if avail.): \_\_\_\_\_

Briefly explain how your disability affects you in everyday living skills i.e., strength, mobility, etc.  
(also include medical diagnosis):

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List the compensating aids and adaptive equipment you are requesting:

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List the exceptions to dress requested:

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List any other allowances requested:

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**PLEASE RETURN APPLICATION WITH MEDICAL DOCUMENTATION TO LAUREEN VIA FAX 908-520-3641  
OR EMAIL, [LKJOHNSON@USEF.ORG](mailto:LKJOHNSON@USEF.ORG),**