



Handicapped Accessibility Self-Evaluation Certification

Organization Name: _____

Address _____

City/State/Zip: _____

Telephone Number: _____

I certify that a handicap accessibility self-evaluation has been;

_____ Completed on _____ (Date)

_____ Partially completed and will be done on _____ (Date)

The result of the self-evaluation(s) is (are) as follows:

_____ The recipients' program, when viewed in its entirety, is accessible and no corrective actions are required.

_____ The recipients' program, when viewed in its entirety, is accessible, but some corrective actions will be made.

_____ The recipients' program, when viewed in its entirety, is not accessible.

FOR SPONSOR ONLY: Corrective action will be made by: _____ (Date)

I understand that, if the organization has 15, or more employees, information on how the self-evaluation was conducted is to be made available for public inspection for 3 years after its completion. I, also, understand that this information will be available to CNS officials upon request.

Signature

Name & Title of Responsible Official

Date