



DISABILITY BUSINESS MEMBER APPLICATION

To be considered for Disability Business Membership, a business must fully complete this Application and submit all of the information requested with respect to the checklist below. While this Application is much more stringent than an application for the typical chamber of commerce, this Application is necessary to establish credibility in the list of Disability Businesses that is promoted to the general public. If you have any questions regarding your business's eligibility for Disability Business Membership or regarding this Application please contact us at info@disabilitychamber.org.

To qualify for Disability Business Membership, your business must be determined to be a Disability Business. That determination is made by the Chamber's Board of Directors (or the membership committee, if such a committee has been appointed), in its sole discretion. **The Board of Directors may request additional information or waive certain requirements in its sole discretion.** The following definition of Disability Business is in accordance with the Chamber's Bylaws:

“Disability Business” means a business (whether for profit or not-for-profit) that is controlled by one or more persons who have a disability and/or are direct caregivers of a person who has a disability.

- (a) The term “controlled” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a company or a division of a company, whether through the ownership of voting securities, by contract, or otherwise.
- (b) The term “disability” has the definition provided in 42 U.S.C. Section 12102(2) and the regulations promulgated thereunder (and any successor law). That Section defines the term “disability” for purposes of the Americans with Disabilities Act of 1990 (the “ADA”). Pursuant to the ADA, the term disability means, with respect to an individual,
 - (i) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
 - (ii) a record of such an impairment; or
 - (iii) being regarded as having such an impairment.
- (c) The term “direct caregiver” means a parent or guardian of one or more individuals with a disability; provided that such parent or guardian is the primary caregiver for such individuals.

Once a business is determined to qualify as a Disability Business, such business shall automatically be deemed a Disability Business Member. There are no membership fees for Disability Business Members.



(Please attach checklist to application with the appropriate boxes marked)

- Submit verifiable evidence of disability (e.g., letter as to qualification for Social Security Disability coverage or doctor letter) for each person listed as disabled in item 9 below;
- Submit verifiable evidence of status as a direct caregiver of a person who is disabled (e.g., document establishing status as guardian) for each person listed as a direct caregiver in item 9 below;
- Submit copies of Articles or other formation documents;
- Submit copies of Bylaws (if applicable);
- Submit copies of Stock Certificates or other proof of ownership;
- Submit copies of minutes (to the extent the minutes indicate control);
- Submit copies of all Shareholder's Agreements, Partnership Agreements, Joint Venture Agreements, or Operating Agreements (as applicable); and
- Submit copies of Resumes for all owners.
- Write "N/A" (Not Applicable) if it applies to any section.

Please mail all forms to:

Chamber of Commerce for Persons with Disabilities, Inc.
6932 Sylvan Woods Drive
Sanford, FL 32771
(407) 650-0926 Facsimile
info@disabilitychamber.org



**INFORMATION FOR DETERMINING
DISABILITY BUSINESS ELIGIBILITY**

If, at any time, the Chamber has reason to believe that any person or business has willfully and knowingly provided incorrect information or made false statements, or acted in a manner prohibited by applicable law, the responsible official shall refer the matter to the appropriate agency.

1. Nature of business: Specify major services / products.

2. Geographical area served:

States: _____ Counties: _____

3. Years business has been in business: _____

4. Type of entity: Check one)

_____ Corporation _____ Partnership _____ Sole Proprietorship
 _____ Joint Venture _____ LLC _____ Other (specify)

5. Ownership of business: Identify those who own 5 percent (5%) or more of the business's ownership. Columns (E) and (F) need to be filled out only if one or more owners is not disabled or a direct caregiver of a person who is disabled (as defined on page 1 of this Application).

A	B	C	D	E	F
Name of Business	Type of Disability *	Disabled (D)/Direct Caregiver (DC)	Years of Ownership	Ownership Percentage	Voting Interest

*The type of disability must be a disability in accordance with the definition on page 1 of this Application.



6. Control of business: Identify by name, disability, whether disabled or a direct caregiver of a person who is disabled, and title in the business of those individuals (including owners and non-owners) who are responsible for day-to-day management and policy decision making including, but not limited to, those with prime responsibility for:

a. Financial decisions: _____

b. Management decisions, such as:

(1) Estimating: _____

(2) Marketing and sales: _____

(3) Hiring and firing of management personnel: _____

(4) Purchases of major items or supplies: _____

7. For each of those listed in number 5, provide a brief summary of the person's experience and number of years with the business, indicating the person's qualifications for the responsibilities given him or her. (Attach a separate sheet if necessary.)

8. Describe or attach a copy of any stock options or other ownership options or other rights that are outstanding and any agreements between owners or between owners and third parties which restrict ownership or control of the disabled owners and/or direct caregiver owners. (Attach a separate sheet if necessary.)



9. Applicable Disability: For each person listed in item 5 above who has a disability, please indicate below the type of disability and how the disability qualifies as a disability in accordance with the definition of disability on page 1 of this Application.

10. Direct Caregiver: If any person listed in item 5 above is listed as a direct caregiver, please indicate below how such person is a direct caregiver (e.g., parent or guardian). Also, for each disabled person who has a direct caregiver listed in item 5 above, please indicate below the type of disability and how the disability qualifies as a disability in accordance with the definition of disability on page 1 of this Application.



AFFIDAVIT

The undersigned swears that the foregoing statements are true and correct and include all material information necessary to identify and explain the operations of _____, as well as the ownership thereof. Further, the undersigned agrees to permit the audit and examination of books, records and files of the named business. Any material misrepresentation will be grounds for terminating membership and for initiating action under Federal and State laws concerning false statements.

Note: If, after filing this Application, there is any significant change in the information submitted, you must promptly inform the Chamber of the change.

Signature: _____

Name (print or type): _____

Title: _____

Date: _____

State of: _____

County of: _____

On this _____ day of _____, 20____, before me appeared (name) _____, to me personally know, who, being duly sworn, did execute the foregoing affidavit, and did state that he or she was properly authorized by (name of business) _____, to execute the affidavit and did so as his or her free act and deed.

Seal:

Notary Public: _____

Commission Expires: _____