**TOWN OF LIVONIA**

**Rules for Remote Participation in Open Meetings by Those with**

**ADA-Recognized Disabilities**

**A. Any member of the governing body of the TOWN OF LIVONIA with an ADA-recognized disability who seeks accommodation to participate and vote in an open meeting of the municipality, or any member of the public with an ADA-recognized disability who seeks accommodation to observe and participate in an open meeting of the TOWN OF LIVONIA, shall complete an application for remote participation and a medical certification of disability on forms provided by the TOWN OF LIVONIA.**

**B. For members of the public who are granted accommodation for ADA-recognized disabilities pursuant to this section, the TOWN OF LIVONIA shall inform a member of the public of the means by which they or their designated caregiver may observe and participate in the open meeting – whether by teleconference or video conference or other viable alternative methods – including the means by which they may submit public comments on agenda items prior to and/or during the open meeting.**

**C. For any meeting in which a council member with ADA-recognized disabilities will participate remotely, the TOWN OF LIVONIA shall post the agenda for the meeting in accordance with the Louisiana Open Meetings Law.**

**D. Members of the municipal governing body who receive accommodation pursuant to this section for an ADA-recognized disability shall be allowed to participate by electronic means in an executive session convened in accordance with Louisiana’s Open Meetings Law. In no instance, however, shall any member of the public be allowed to observe or participate in an executive session of the governing body.**

**E. The meeting’s presiding officer shall ensure that each person participating in the meeting is properly identified, and that all parts of the meeting (excluding executive sessions) are clear and audible to all participants. The vote of every member of the governing body, including those participating by electronic means, shall be clearly identified and recorded in the minutes of the meeting.**

**F. If a technical problem arises impairs the ability of the disabled member of the public or disabled member of the public body to participate in the meeting, the meeting shall be recessed until the problem is resolved. If the technical issue is not resolved within one hour, the meeting shall be adjourned, and the presiding officer will use all reasonable means to notify all participants of that fact.**

**Application for Council Member to Participate Remotely in Public Meeting and Medical Certification of Disability**

Name of Council Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meeting(s) for which you are requesting remote access accommodation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with a disability recognized by the Americans with Disabilities Act? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently diagnosed with this disability? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does the functional limitation caused by your disability affect your ability to participate in and vote during and in-person public meeting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that submitting false or incomplete information on this form may subject me to penalties, including that I may be found ineligible to participate remotely in public meetings. I understand that my virtual attendance will be counted toward a quorum and that I am subject to all other applicable provisions of Louisiana’s Open Meetings Law regarding such participation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Council Member’s Signature Date of Signature

**Certification of Medical Professional**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Professional’s Name), am a medical professional and am currently licensed to practice in the United States of America in the field of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. My address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
3. My office telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
4. I have examined and am familiar with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of applicant).
5. I confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of applicant) has a current, clinical diagnosis of a disability that is recognized by the Americans with Disabilities Act.
6. I confirm that this diagnosis would affect the ability of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of applicant) to participate in and vote at a meeting in person.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Medical Professional Date of Signature (mm/dd/yyyy)