Instructions: When medical verification is needed for qualification purposes under the Americans with Disabilities Act, the employee/applicant shall complete this form and mail/deliver it to their treating health care provider. The treating health care provider should return the requested information to the address below. A carbon copy, photocopy, or facsimile copy of this true medical release shall be as valid as an original of same. Telecommunications needs: Please use the California Relay Service at (877) 735-2929 TTY.

To: 
Treating Health Care Provider

Re: 
Employee or Applicant Name (Please Print)

NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT. You are hereby authorized to deliver, disclose, and release information regarding verification of my disability, as well as my medical restrictions/limitations resulting from my disability to:
Attn: Human Resources/ADA Coordinator
The California Maritime Academy
200 Maritime Academy Drive
Vallejo, CA 94590

Treating Health Care Provider: Please complete the following information for the employee/applicant.

Major life activity limited by the impairment:
- Walking
- Speaking
- Breathing
- Hearing
- Seeing
- Thinking
- Sitting
- Standing
- Reaching
- Interacting with Others
- Learning
- Performing Manual Tasks
- Caring for Oneself
- Concentrating
- Lifting
- Sleeping
- Working
- Other_____________(describe)

Verification of disability and resulting medical restrictions/limitations (please print; use additional pages as necessary):
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Signature of health care provider __________________________ Type of Practice __________________________ Telephone Number __________________________
Provider Address: __________________________________________ Date: ______/_____/______
Employee/Applicant Signature: ________________________________ Date: ______/_____/______
Verified by Human Resources: ________________________________ Date: ______/_____/______