VERIFICATION OF DISABILITY & AUTHORIZATION
For Release of Medical Information

Instructions: Employee/applicant shall contact the treating Medical Doctor (M.D.) to complete this form. Employee/applicant should return the completed form to the Department of Human Resources. Individual in need of a telecommunication relay service may contact the California Relay Service at 877.735.2929 TTY.

Treating M.D. (Please Print): ____

Employee or Applicant (Please Print): ____

1) Does the individual have a physical or mental impairment that limits one or more major life activity?
☐ Yes ☐ No *If no, you may stop. No further information is required.*

If yes, please identify the job functions that the employee is unable to perform:

☐ Breathing ☐ Hearing ☐ Reaching ☐ Sleeping ☐ Thinking ☐ Caring for oneself ☐ Reading
☐ Interacting with Others ☐ Reading ☐ Speaking ☐ Walking ☐ Communicating ☐ Lifting
☐ Seeing ☐ Socializing ☐ Working ☐ Concentrating ☐ Performing Manual Tasks ☐ Sitting
☐ Standing ☐ Other (describe): ____

2) Approximate date impairment commenced: ____

3) Probable duration of condition: ____

4) Is the individual able to perform the essential functions of the job as described in the job description? If employee fails to provide a job description, answer the question based on the employee's description.
☐ Yes ☐ No

5) Additional restrictions/accommodations suggestions (please include any additional information that you believe would be helpful to the interactive process of the employee). **Do not list any information pertaining to diagnosis, condition, or treatment.**

Signature of M.D. ______________________________ Date: ______________________________

Type of Practice: ______________________________

Telephone Number: ______________________________

Provider Address: ______________________________