Verification of Disability and Authorization for Release of Medical Information

**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: _____/_____/_____

9/06