



## 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:*

- |  |
|--|
| <input type="checkbox"/> Breathing <input type="checkbox"/> Hearing <input type="checkbox"/> Reaching <input type="checkbox"/> Sleeping <input type="checkbox"/> Thinking <input type="checkbox"/> Caring for oneself <input type="checkbox"/> Reading<br><input type="checkbox"/> Interacting with Others <input type="checkbox"/> Reading <input type="checkbox"/> Speaking <input type="checkbox"/> Walking <input type="checkbox"/> Communicating <input type="checkbox"/> Lifting<br><input type="checkbox"/> Seeing <input type="checkbox"/> Socializing <input type="checkbox"/> Working <input type="checkbox"/> Concentrating <input type="checkbox"/> Performing Manual Tasks <input type="checkbox"/> Sitting<br><input type="checkbox"/> Standing <input type="checkbox"/> Other (describe): _____ |
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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.**

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Signature of M.D. \_\_\_\_\_ Date: \_\_\_\_\_

Type of Practice: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Provider Address: \_\_\_\_\_