WESTERN MICHIGAN UNIVERSITY

Disability Verification Form

TO BE COMPLETED BY EMPLOYEE:

Name:______________________________ **Date of Birth:**____________________

Address:______________________________ **Home Phone:**____________________

City:____________________ **State:**______ **Work Phone:**____________________

Zip:______________ **WMU Department:**______________________________

I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, autoimmune deficiency syndrome (aids), aids-related complex (arc), or human immunodeficiency virus (hiv) infection for any clinic visits.

I UNDERSTAND that I have the right to revoke this consent at any time unless the facility which is to make the disclosure of information has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid until it expires six (6) months from the date signed below or until the following date, event, or condition:____________________

I UNDERSTAND that I have the right to a copy of (for a fee) or to inspect the disclosed information if so requested.

I HEREBY RELEASE THE BELOW LISTED PHYSICIAN, FACILITY, ITS EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILTY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY FILE.

Patient (or authorized person):______________________________ Dated:____________________

Signature

TO BE COMPLETED BY LICENSED PHYSICIAN

Diagnosis:____

Date of Diagnosis:____________ Date first saw patient:____________ Date last saw patient:____________

Basis on which diagnosis was made:______________________________

How does the disability impact work performance:______________________________

Prognosis:____

Treatment regimen:____

Specific limitations:____

Suggested accommodation(s):____

Patient Name:____

Signed:____ Date:_____________________________

Printed Name:____ Degree:___________________________

Address:____ Phone:____________________________

City:__________________________________State:______________ Zip:______________________________

Additional Comments (if necessary):