

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 RESPONSIBILITY 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 HEALTHCARE PROVIDER

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): _____

Disability Verification Form

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Patient Name: _____

Signed: _____

Date: _____

Printed Name: _____

Degree: _____

Address: _____

Phone: _____

City: _____ State: _____

Zip: _____

Additional Comments (if necessary):