WESTERN
NEW MEXICO UNIVERSITY

Authorization for Release of Medical Information

I, _____
First Name Middle Name Last Name

_____
Address

Hereby Authorize:

_____
Name of Medical Provider Releasing Information

_____
Name of Medical Organization Releasing Information

_____
Address of Medical Provider or Medical Organization

To release to Western New Mexico University's Human Resources Director my medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, Reasonable Accommodation Subject Matter Expert, hospital, clinic, or other medically related facility or United States Veteran Administration: I authorize you to release to Western New Mexico University's Human Resources Director my medical information to be used solely for the purpose of evaluating my request for a reasonable accommodation. This authorization shall be valid for a period of 90 days after the date of my signature or earlier if revoked by me in writing to WNMU. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

_____ _____
Printed Name Employee Signature

_____
Date

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American Disabilities Act – Medical Certification Form

APPLICANT / EMPLOYEE INFORMATION	
Name	
Address	
W#	Department
REASONABLE ACCOMMODATION (attach additional documentation or information as needed):	
1. Please discuss the position with our employee to determine essential job duties. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes / No	
2. Does the employee have a disability? Yes / No	
3. What is the disability?	
4. Is the disability □ Ongoing □ Temporary □ Unknown □ Does not apply If temporary, Anticipated Date accommodation will no longer needed:	
5. What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job functions?	
6. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?	
7. The employee's typical schedule is Monday through Friday 8:00 to 5:00PM. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?	

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8. How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically revaluated?

9. Any additional comments or suggestions:

Verification by a health professional for your reasonable accommodation must meet the following criteria:

1. Documentation must provide a diagnosis of disability and include a medical recommendation for a specific reasonable accommodation.
2. The health professional's credentials must be identified.
3. The documentation must be dated and signed.
4. Describe the limitations in detail as they currently exist and only in relationship to the job, and state whether the disability is ongoing or temporary. If temporary, specify the date the disability is expected to no longer require an accommodation.
5. Indicate the extent to which the accommodation will permit the employee to perform the essential functions of the job.
6. If equipment purchase is recommended, please be specific. If work modification is recommended, or restructuring or sharing of specific duties, please be specific in the description of the recommended actions.

Name of Medical Provider

Signature of Medical Provider

Name of Medical Organization

Date

Address of Medical Provider or Medical Organization