Print Form Reset Form

California State University, Los Angeles

CONFIDENTIAL

Americans with Disabilities Act (ADA)
Request for Reasonable Accommodation

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete and return along with your *Request for Reasonable Accommodation Form*.

This release will be submitted to your doctor(s) in the event that additional information is needed regarding the medical condition(s) for which you are requesting reasonable accommodation(s).

1. Name: _____ **Employee I.D. No.** _____

2. Home Address: _____ **Home Phone:** _____

3. Department: _____ **Job Title:** _____ **Ext:** _____

4. Physician's Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

5. Physician's Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

I hereby authorize California State University, Los Angeles, or its agent, to contact Dr.(s):

_____

_____

to request and obtain information about my functional abilities, my functional limitations, and any requirements for reasonable accommodation for which I am requesting a reasonable accommodation(s).

Signature: _____ **Date:** _____

For use only by the Office for Equity and Diversity. **09/2011**