COLORADOSCHOOLOFMINES
EARTH • ENERGY • ENVIRONMENT

AMERICANS WITH DISABILITIES MEDICAL CERTIFICATION FORM AND HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

PART 1: TO BE COMPLETED BY THE EMPLOYEE

I, _____ authorize and request

_____ (name of healthcare provider) to disclose all protected information for the purpose of review and evaluation in connection with my request for a work accommodation consistent with the Americans with Disability Act to my employer, Colorado School of Mines, Human Resources staff. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information (facts and opinions) regarding my medical disability or condition resulting in my request for an ADA accommodation and any limits on my ability to perform the functions of my job.

I understand the following: See CFR §I64.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, email attachment, or photocopy of this authorization shall authorize you to release the information requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires or if sooner by written revocation.

_____
Print Name

_____ _____
Signature Date

_____ _____
Social Security Number(last four) Date of Birth

COLORADOSCHOOLOFMINES
EARTH • ENERGY • ENVIRONMENT

PART 2: TO BE COMPLETED BY HEALTHCARE PROVIDER

HEATHCARE PROVIDER INFORMATION	
Name:	**Address:**
Preferred Phone Number:	**Preferred Email Address:**

INSTRUCTIONS: Please fill out this entire form and return to HR@mines.edu. If you have any questions or need clarification, please call Craig Hess, Human Resources Director, at 303.273.3390.

For purposes of this form, a qualifying disability or condition is one that substantially limits one or more major life activities e.g., caring for self, doing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting.

1. Does the employee have a physical or mental disability, condition, or impairment?

   Yes ☐ No ☐

   If no, please sign, date and return the form to HR@mines.edu. If yes, please describe the physical or mental disability, condition, or impairment.

2. Is the physical or mental disability, condition, or impairment permanent? Yes ☐ No ☐

   If not permanent, how long will the physical or mental disability, condition, or impairment likely last?

   If not permanent, will the physical or mental disability, condition, or impairment improve on an approximately date or will it improve gradually over time?

   If there is a specific date, please provide your best guess of that date.

If gradual, please explain the requested accommodation, i.e. work 6 hours a day one week, increase to 7 hours a day the second week and 8 hours a day on the third week.

3. Does this physical or mental disability, condition, or impairment require periodic visits for treatment by a healthcare provider? Yes ☐ No ☐

   If yes, please explain?

4. If yes, can these visits be scheduled early in the morning, late in the afternoon or over weekends? Yes ☐ No ☐

   If not, please describe the days of the week and hours available for these visits.

5. Does this physical or mental disability, condition, or impairment cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐

   If yes, please explain?

6. If yes, are there steps we can take as the employer to reduce the possibility of an episodic occurrence? Yes ☐ No ☐

   If yes, please describe those steps.

COLORADOSCHOOLOFMINES
EARTH • ENERGY • ENVIRONMENT

7. Has the patient been prescribed medications or treatments that may impact job performance or would pose a safety risk to either themselves or other? Yes ☐ No ☐

   If yes, please explain.

   If yes, are there alternative medications or treatments that may be utilized that would provide the employee with the same or similar results that may not impact job performance or pose a safety risk to either themselves or other? Yes ☐ No ☐

   Please explain?

8. Does the physical or mental disability, condition, or impairment impact a major life activity e.g., caring for self, doing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting?

   Yes ☐ No ☐

   If yes, please list the life activity and describe how the physical or mental disability, condition, or impairment is impacting the life activity.

9. After reviewing the employee's job description, please describe which job functions the employee is unable to perform because of their physical or mental disability, condition, or impairment.

10. Please suggest any accommodations that would enable the employee to perform all their duties and describe how the accommodation will remedy the current limitation.

COLORADOSCHOOLOFMINES
EARTH • ENERGY • ENVIRONMENT

11. Please provide us any additional information that you believe will assist us in making a determination regarding the employee's ADA claim.

_____
Print Name

_____ _____
Signature Date

_____
Specialty