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

Patient Name: _____

Signed: _____ Date: _____

Printed Name: _____ Degree: _____