

CONFIDENTIAL

**Chicago Public Schools
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: Ms. Mrs. Mr. _____ Employee I.D. No. _____
(Circle One)

2. Address: _____ Phone: _____

3. Work Location: _____ Job Title: _____
_____ Phone: _____

4. Physician's Name: _____

5 Address: _____ Phone: _____
_____ Fax: _____

6. Physician's Name: _____

7. Address: _____ Phone: _____
_____ Fax: _____

I hereby authorize Chicago Public Schools, or its agent, to contact Dr.(s)

_____ to request and obtain all medical information related to the current health condition(s) for which I am requesting a reasonable accommodation(s).

Signature: _____ Date: _____

For use only by the ADA Administrator. This information is CONFIDENTIAL.