1401 Parkmoor Avenue, Ste. 125
San Jose, CA 95126
Phone: 408-557-0880
Fax: 408-343-7054

Instructions for completing your Verification of Disability form:

1. Complete the client identification section of page (1) with your name, signature and date.
2. Forward both pages (1) and (2) to your physician or other qualified professional. They should complete page (2) and return ONLY page 2 to Project HIRED by mail, fax or other means. **Be certain that the doctor prints your name in section (A) of the Disability Verification form. We cannot accept forms that do not have your name included in section (A)** You may also return it to us in person.
3. Complete page (3), **Authorization for Release of Information** and return to Project HIRED. This form authorizes Project HIRED staff to review your information for eligibility.

If you have any questions about the completion of the forms please call our main office at 408-557-0880 (voice/VRS), email info@projecthired.org or TTY/TDD 408-244-3241

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Dear Physician/Health Care Worker:

Project HIRED is an industry-initiated non-profit employment service that assists both employers and job seekers with disabilities. We provide job placement services for permanent and temporary jobs.

Your patient or client listed below, has applied for services. We would appreciate your assistance in providing relevant information about your patient's disability as it relates to employment. Project HIRED is **required** to have a written verification of disability signed by a licensed practitioner on file before we can offer services to an individual.

If you have concerns regarding the release of this information, or prefer to release this information directly to a Project HIRED staff member, please note that on the attached form and a program staff member will contact you to obtain the necessary information.

Thank you for your time.

Sincerely,
Project HIRED

JOB SEEKER: PLEASE SIGN HERE BEFORE FORWARDING TO YOUR PROVIDER:

I,._____ give my permission to release
(print name)
medical and/or disability related information to Project HIRED for the purposes of defining me as disabled to qualify for employment services.

Signature: _____ Date: _____

Project HIRED
Verification of Disability for Job Placement Services

Please complete all sections. If you marked the box in section A, you may proceed to section C. If you have any questions, please call Project HIRED at (408) 557-0880

Section A: Patient identification

Patient's Name: _____

Patient Phone Number: _____ **Date of Birth:** _____

Section B: Preference for Release of Information

❑ It is my/our practice policy (or personal preference) to not release medical information directly to the patient. Please have a Project HIRED staff member contact me directly. **(If you checked this box please proceed directly to Section "D")**

Section C: Disability Verification

Diagnosis:_____Date of onset:_____

Disabling condition is likely to: ❑ Improve ❑ Stay the same ❑ Deteriorate

Job-related limitations/restrictions: _____

_____

Medications/side effects: _____

_____

Other comments useful in job placement relating to performance on the job:

_____

_____

_____

Section D: Signature & Contact Information

Physician Name and Title:_____

(Please print)

Physician Signature:_____

License Number or Certification: _____

Phone Number: _____Date: _____

Thank you for your time in completing this information. Please return this form to your patient or you may fax it to 408-343-7054.
If you have any questions, please call Project HIRED at (408) 557-0880

AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: Please complete the top half of this form and initial next to each area in which you would have education, vocational, work-search or disability-related areas. This form, and the information obtained from these sources, is STRICTLY CONFIDENTIAL.

I hereby request and authorize the release to Project HIRED the following types of information pertaining to me:

Requested Information	**Applicant's Initials**
School	_____
Employment History	_____
Work Evaluations	_____
Psychological Testing/Reports	_____
Psychiatric Evaluations	_____
Hospital & Medical Records Reports	_____
Department of Rehabilitation Records	_____
Other *Please Specify:* _____	_____

Social Security Number: _____ - _____ - _____ Date of Birth: ____ / ____ / _____

Applicant's Full Name (Please Print): _____

Signature: _____ Date: ____ / ____ / _____

This release is valid for one year.

The individual listed above has applied to Project HIRED for job placement services and has signed this authorization for release of information. I would appreciate your sending the requested reports from your files. Project HIRED is a free employment service that assists disabled persons in finding employment. There is no fee to the employer or applicants. We do not have the funds to pay doctor fees to obtain client health records. PLEASE contact this office if you are unable to send records or if you have any questions regarding Project HIRED.

Thank you,
Project HIRED Staff

Please return completed form to Project HIRED. The information contained herein is considered strictly private and confidential.