



**CANYONS**  
School District  
*"Celebrating the Highest  
Standards of Educational Excellence"*

*Legal Services*  
**9361 South 300 East**  
**Sandy, UT 84070**  
**801-826-5061 Phone**  
**801-826-5098 Fax**

## LIMITED MEDICAL RELEASE

The information and relevant documentation requested is to support my request for a reasonable accommodation under the ADA from Canyons School District. I, \_\_\_\_\_ (print name), authorize release of my physical and/or mental health information describing the nature, severity, duration, limiting impairment, activities limited by the impairment, medical restrictions, and any medical recommendations for accommodation.

PHYSICIAN(S) TO CONTACT: Please print clearly

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, STATE, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Comment:

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Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, STATE, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Comment:

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\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date