

**Certification of Disabilities**  
Kept on each disabled employee

1. Member:

\_\_\_\_\_

2. Employee/Client Name:

\_\_\_\_\_

Full Time      Part Time

3. Employee/Client Number: \_\_\_\_\_

4. Qualifying disability:

\_\_\_\_\_

5. Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      6. Termination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

7. Position Held and Brief Summary of work performed:

\_\_\_\_\_  
\_\_\_\_\_

8. Referral Source: \_\_\_\_\_

9. Documentation of Medical Impairment

- Disability Determination from Physician  
(The medical document must include a statement that the disability presents a substantial impairment to employment.) or,
- Documentation of Medical Impairment and a Disability Determination from a Vocational Rehabilitation Specialist. Disability Determination worksheets are contained in the Forms section.

I certify that to the best of my knowledge the information furnished on this form is accurate. I understand and acknowledge that the above representations are material and important and will be relied upon by the State of New Mexico. Any intentional misrepresentation on this form is and shall be treated as fraudulent concealment of the true facts and may subject me to criminal penalties.

\_\_\_\_\_  
Signature (Name & Title)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**Comments: (Attach pages as necessary).**