**Certification of Disabilities for New Mexico Abilities**
Kept on each individual with a disability

1. Member: ______________________________________________________________

2. Employee/Client Name:
__________________________________________________________________

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

- ☐ Proof of eligibility from the Department of Vocational Rehabilitation
- ☐ Proof of eligibility from the Commission for the Blind
- ☐ Documentation from SSI/SSDI
- ☐ Medicaid Waiver
- ☐ Disability from the Veterans Administration
- ☐ 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.
- ☐ Other _______________________________________________________

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).**