

REQUEST FOR ACCOMMODATION PURSUANT TO THE  
AMERICANS WITH DISABILITIES ACT  
CONSENT, RELEASE & WAIVER FORM  
FOR REVIEW OF PERSONAL MEDICAL RECORDS

I, \_\_\_\_\_, am seeking to participate in the  
\_\_\_\_\_ [name of competition]  
competition to be held on \_\_\_\_\_ [date]. I intend to compete in  
the following events at the Competition:

\_\_\_\_\_  
However, in order to compete I will need an accommodation due to

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ [describe disability/medical condition].

I understand that in order for USA Track & Field, Inc. (USATF) to evaluate my request and conduct an individualized inquiry regarding my asserted disability, and the accommodation that I am requesting, it will be necessary for a representative of the USATF Sports Medicine & Science Committee to review personal medical information supplied by me and/or my medical provider. I hereby consent to having the USATF Legal Department forward my personal medical information, ***confidentially***, to a representative of the USATF Sports Medicine & Science Committee, who is a licensed medical professional, for an assessment of my asserted disability. I also waive any privacy rights that I have and agree to permit my personal treating physician, or other medical professional identified by me, to communicate directly with the representative of the USATF Sports Medicine & Science Committee if USATF needs follow-up information. I understand that USATF will handle all my personal medical information in a ***confidential*** manner, and I agree to forward such information only to the USATF Legal Department at 132 E. Washington Street, Suite 800, Indianapolis, IN 46205 or [lamont.jones@usاتف.org](mailto:lamont.jones@usاتف.org).

I understand that USATF will only use my personal medical information for the purpose of determining my eligibility for an accommodation, pursuant to the Americans with Disabilities Act. Furthermore, upon completion of the review of my personal medical information and the rendering of a decision related to my accommodation request, USATF will either destroy the medical records that I have provided, or return them to me.

I knowingly agree to release, waive, discharge and hold harmless USATF, its employees, agents and volunteers, and the representatives of the USATF Sports Medicine & Science Committee who review my personal medical information, from and against any and all liability, loss, claims, demands, costs (including medical or legal), and/or damages resulting from, or arising in connection with, their handling of my personal medical information, or their communications with my personal treating physician or other medical professional identified by me.

My signature below constitutes my consent to and agreement with the above-described terms and conditions.

\_\_\_\_\_  
Printed name

Date:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Printed name

Date:

\_\_\_\_\_  
Signature

**Note: In addition to the applicant, a witness must counter-sign this Consent, Release and Waiver form, otherwise the form will be returned and the ADA accommodation request process will be delayed.**