EMORY UNIVERSITY | Accessibility Services
Office of Equity and Inclusion

PARKING ACCOMMODATION: STATEMENT OF MEDICAL NECESSITY

Physician Name: ____

Specialization/Type of Practice: ____

DEA/License Number: ____

Work Address: ____

Telephone Number: ______________________________

Please provide specific medical information associated with the employee's condition relative to their limitation and need for accessible/reserved parking.

Patient Name: ______________________________ **Date of Birth:** ____________________

Disability/Impairment: ____

Restrictions/Limitations: ____

List Duration: ☐ **Permanent** ☐ **Temporary (Dates: From:**________**To:**____________)

Wheelchair/Mobility Equipment Required: Type ______________________________

☐ **Yes (Dates: From:**_________**To:**_________) ☐ **No**

List Distance:________________**Feet or**______________**Yards Employee is able to walk**.

Indicate Elevation/Step Limit:

☐ **No Limit** ☐ **Limit (Approximately**__________**steps or**_____________**feet)**

PHYSICIAN'S CERTIFICATION

I certify that the information provided on this form is true and accurate. I understand the information provided on this form will remain confidential and only used for the purpose of providing a reasonable accommodation under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA).

________________________________ ________________

Signature of Physician Date

RETURN FORM TO:
Emory University
Department of Accessibility Services
Phone: 404-727-9877 | Fax: 404-727-1126
Email: oas_employee@emory.edu