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