EMORY UNIVERSITY

Accessibility Services

Office of Institutional Equity and Compliance

PARKING ACCOMMODATION: MEDICAL NECESSITY STATEMENT

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:** _____

Diagnosis/Impairment: _____

List Duration: □ **Permanent** □ **Temporary (Dates: From:** _____ **To:** _____)

Mobility Assistive Devices Required: _____

□ **Yes (Dates: From:** _____ **To:** _____) □ **No**

Employee is limited from walking more than _____ **Feet, and** _____ **Stair Steps**

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 be used to provide 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
Email: dasemployee@emory.edu
Phone: 404-727-9877 | Fax: 404-727-1126