EMORY UNIVERSITY | Accessibility Services
Office of Institutional Equity and Compliance

Disability Verification Form for Parking Accommodations
Emory University - Department of Accessibility Services (DAS)

Purpose of this form:

The Department of Accessibility Services DAS provides accommodations for individuals with disabilities. The purpose of this form is to assist healthcare providers in documenting a individual's relevant disability information for determining accommodation eligibility.

To the healthcare provider:

An Emory student has requested disability-related accessibility accommodations. The information you provide below will be used to inform the interactive process while reviewing an accommodation request. With the student's permission, we may contact you directly for additional information to assist us in making a determination.

Please complete this form thoroughly in English, and type responses if possible. Inadequate information or illegible handwriting may delay the review process. Even if the patient doesn't have a diagnosis, please complete the form to the best of your ability. DAS cannot accept documentation written by a family member.

Please include any additional supporting documentation if relevant (e.g., test results, evaluations, previous accommodations.

Confidentiality:

All information provided will be kept confidential and used solely for the purpose of determining reasonable accommodations.

Submission Instructions:

Emory students can upload documents directly to the Accommodate portal by logging in with your NetID and password and navigating to "Upload Documents" under "Accommodations" on the left side of the portal.

Completed forms can be submitted to the Department of Accessibility Services at Emory University.
Email: accessibility@emory.edu **Fax:** 404 727-1126

Patient Information:

Patient name:	Date of initial visit:
Date of birth:	Date of last visit:
	Number of patient visits:

Diagnosis and Functional Limitations

Primary diagnosis:	Secondary diagnosis (if applicable):
Date of diagnosis:	Date of diagnosis:
Duration *(temp, etc):*	Duration:
Method to diagnose:	Method to diagnose:

1. How does the condition impact the patient's ability to walk, stand for extended periods, navigate inclines, stairs, or uneven terrain, and access shuttle transportation options? Please describe the patient's mobility limitations, including the approximate distance they are able to walk (in feet or yards), any stair or elevation limitations, and whether mobility equipment is required.

2. Is the condition permanent, temporary, and/or episodic/fluctuating? If applicable, what is the typical duration and frequency of symptoms or flare-ups? Are there any factors that exacerbate or alleviate symptoms?

3. If recommending proximity or parking accommodations, please explain why alternative strategies (for example, mobility devices, campus transportation services, scheduling adjustments, or other supports) would not sufficiently address the functional limitation.

4. Additional information or considerations that may aid in the exploration of reasonable accommodations including barriers that may need to be addressed in the university setting.

Provider Information:

Provider name:	Credentials & license number:
Phone number:	Email:
Office address:	

I certify that I am a licensed healthcare provider and that the information provided above is accurate and to the best of my professional knowledge. My responses reflect the patient's current functional limitations.

Provider signature:	Date: