

# ACCESSIBLE PARKING: MEDICAL DISABILITY VERIFICATION FORM

## TEMPORARY PARKING ACCOMMODATION FORM

**Overview:** The applicant named in Section 1 of this form has requested accessible parking to accommodate their disability /condition while employed at the University of Waterloo (UW). The Employee Health and Accommodations (EHA) office at the University will use this information to verify that the applicant has functional limitations that constitute a disability requiring reasonable accessible parking accommodations.

All information gathered by EHA will be reviewed to determine eligibility for reasonable accessible parking accommodation support. Reasonable accommodation support is individually determined and based on the functional impact(s) of the disability / condition, and how it is likely to interact with the demands of navigating campus including parking locations. Parking Lot assignments are determined by Sustainable Transportation, according to the level of functional limitations in conjunction with an appraisal of the parking options available to accommodate the need. Please note that the submission of the *Accessible Parking: Medical Disability Verification Form* does not guarantee access to a particular lot nor a particular spot.

This form is to be completed by you (the employee) and your health care practitioner who has in-depth knowledge of your functional limitations. The purpose is to identify functional limitations that are causing barriers specific to the parking services available on campus.

**Registered Health Professional:** Documentation and all relevant information must be completed by a registered health professional qualified to diagnose. The applicant is required to provide the University with information that is based on a current, thorough and appropriate assessment.

**Please note:** any costs associated with obtaining or providing this documentation are the responsibility of the employee.

### TO BE COMPLETED BY EMPLOYEE

#### SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE INFORMATION (PLEASE PRINT)	
First and Last Name:	
WatIAM	
UWaterloo Email (WatIAM)	@uwaterloo.ca
Personal Email Address ( <i>optional</i> )	
EMPLOYEE PARKING INFORMATION	
Current UW Parking Permit #	
Current UW Assigned Parking Lot	

#### SECTION 2: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, including any medical diagnosis(es), is kept ***strictly confidential***. It is not shared with anyone outside of Employee Health and Accommodations, including with other university departments, without the expressed and written consent and/or direction of the employee.

By signing below, I give consent for the University of Waterloo Employee Health and Accommodations office to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Employee's signature:	Date completed (DD/Month/YYYY):
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Applicant's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.



## TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to diagnose the medical condition and provide an assessment of the associated functional limitations** associated with the medical condition(s) /disability (i.e. Physician, Nurse Practitioner, Physiotherapist, etc.).

### SECTION 3: VERIFICATION OF DISABILITY

- Permanent, continuous:** Ongoing functional limitations that will impact the employee over the course of their career and are unlikely to change
- Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their career
- Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in the future. Employee to be reassessed by: \_\_\_\_\_ (DD/Month/YYYY)
- Provisional:** I am still monitoring/assessing the individual. Assessment is likely to be completed by: \_\_\_\_\_ (DD/Month/YYYY)
- No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the workplace environment

### SECTION 4: FUNCTIONAL LIMITATIONS

1. Does your patient currently have an [Accessible Parking Permit](#) through the Ministry of Transportation (MTO)?:  
 Yes       No  
*If Yes: please disregard this form and direct the employee to contact Employee Health and Accommodation for next steps.*
2. Would your patient meet the eligibility requirements for an [Accessible Parking Permit](#) with the Ministry of Transportation(MTO)? Please explain:
3. Please describe the nature of the disability/ disabling condition resulting in the need for accessible parking:
4. What are the functional limitations/restrictions resulting from the disability? (E.g. What is the maximum distance your patient can walk/ambulate at a time?)
5. What mobility aides (if any) does your patient use to ambulate safely indoors and outdoors?
6. What is the anticipated duration of the identified functional limitations/restrictions resulting in the need for accessible parking? (Duration in days/weeks/months?)



**Additional information** (Please use this space to provide any other information about the applicant’s disability and their functional limitations that the University of Waterloo should consider):

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**SECTION 5: CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER**

*Documentation completed by a relative of the patient/employee will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.*

<b>Practitioner Name (Please print):</b>	
<b>Practitioner Signature:</b>	
<b>Practitioner License/ Registration #:</b>	
<b>Specialty:</b>	<input type="checkbox"/> Family Physician <input type="checkbox"/> Physician (Specialty: _____) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Other: _____
<b>Address/Clinic Name:</b>	
<b>Phone #:</b>	
<b>Fax #:</b>	

**Date Completed:** \_\_\_\_\_ (DD/Month/YYYY)

Affix card here or office stamp

