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**Temporary Parking Accommodation Form**

In order for the University to consider the most appropriate accommodation, please provide the following information to assist in identifying potential solutions:

**Employee Name: Department: Building:**

**Contact Phone: Home Parking Lot: Preferred Lot:**

**Current MTO permit: Y/N** (If yes, please disregard form and contact Occupational Health)

**Please have your Physician provide the following information:**

1. Please describe the nature of the disability resulting in the need for parking accommodation.

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1. What are the functional limitations/restrictions resulting from the disability?

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1. How long will your patient require the accommodation? (ie Prognosis for full recovery) in days/weeks/months?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is there a loss of autonomy during outdoor movement/ambulation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What mobility aides (if any) does your patient use to ambulate safely indoors and outdoors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What is the maximum distance your patient can walk at a time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Can your patient move outdoors without risk of illness or trauma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Would your patient meet the eligibility requirements for an Ontario Accessibility Parking Permit with the Ministry of Transportation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Please provide any additional information that may be useful in processing this accommodation request

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**Physician/Practitioner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**To be completed by employee:**

**\*\*Please note: Traveling to and from work is the employee’s responsibility. However, the University will work with each individual and assist in developing alternate arrangements to accommodate a disability. Parking Services cannot guarantee immediate availability, and any arrangements are subject to change depending on the current needs and requirements. We will do our best to place you as close to your building as possible, subject to availability.**

All information solicited is held in strict confidence. Only functional information will be shared with Parking Services and your manager (if applicable) to develop the most feasible solution.

By signing below, I acknowledge and understand that alternate parking arrangements are subject to availability and changes. I understand that information regarding my functional abilities, restrictions and/or limitations may be shared with my manager, Safety Office, Parking Services and/or relevant departments in order to identify reasonable accommodation solutions for Parking.. I understand that medical information, if any, will be held in strict confidence within Occupational Health.

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Employee Signature Date

Upon completion, please forward this form to Occupational Health at: occupationalhealth@uwaterloo.ca or Fax: 519-888-4373