Temporary Parking Accommodation Form

In order for the University to provide 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.
   __________________________________________________________________________________________
   __________________________________________________________________________________________

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

3. How long will you require the accommodation? (ie Prognosis for full recovery) in days/weeks/months?
   __________________________________________________________________________________________

4. Is there a loss of autonomy during outdoor movement/ambulation? ________________________________

5. What mobility aides (if any) does your patient use to ambulate safely indoors and outdoors?
   __________________________________________________________________________________________
   __________________________________________________________________________________________

6. What is the maximum distance your patient can walk at a time? ________________________________

7. Can your patient move outdoors without risk of illness or trauma? ________________________________

8. Would your patient meet the eligibility requirements for an Ontario Accessibility Parking Permit with the Ministry of Transportation? ________________________________
9. Please provide any additional information that may be useful in processing your accommodation request
________________________________________________________________________________
__________________________________________________________________________________

Disclaimer:

**Please note: The University will work with each individual to provide a reasonable accommodation solution. It is your responsibility to participate in the accommodation process, including review of all reasonable, appropriate accommodation options. All information solicited is held in strict confidence. Only functional information will be shared with your manager (if applicable) to develop the most feasible solution.

By signing below, I agree to participate fully in the accommodation process, including review of all reasonable, appropriate accommodation options. 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 and/or Job duties. I understand that medical information, if any, will be held in strict confidence within Occupational Health.

________________________________________  ______________________________________
Employee Signature                      Date

Physician/Practitioner’s name: ________________________________

Phone number: ____________________________________________
              ____________________________________________

Signature                     Date

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