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