

## Parking Accommodation Medical Form

The Accessibility and Accommodations Division (AAD) of the Office for Access and Equity is requesting your assistance in facilitating a parking accommodation for a University of Illinois employee who has requested a parking accommodation per the Americans with Disabilities Act Amendment Act (ADAAA). The employee listed below has informed AAD of their diagnosis. This form helps AAD determine how to best accommodate the employee, when possible. When an employee requests a parking accommodation this form must be completed and signed by the current treating health care provider. **Providers: please fax documentation to the Accessibility and Accommodations Division at 217-244-9136.** If you have any questions, please contact 217-333-0885 or [accessibility@illinois.edu](mailto:accessibility@illinois.edu). **Employees: please upload this document to your case.**

### Section 1: Completed by employee

Employee Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Employee UIN: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

### Section 2: Completed by Health Care Provider

#### Employee's Diagnosis

Please identify the diagnosis(es) for the above-named employee/patient:

\_\_\_\_\_

#### Check all that apply (*must check at least one*):

- Patient is restricted by a lung disease to such a degree that the person's forced expiratory (respiratory) volume (FEV) is one second, when measured by spirometry, is less than one liter
- Patient uses a portable oxygen device
- Patient has a Class III or Class IV cardiac condition according to the standards set by the American Heart Association
- Patient cannot walk without the assistance of a wheelchair, walker, crutch, brace, and other prosthetic device or without the assistance of another person
- Patient is severely limited in the ability to walk due to an arthritic, neurological, oncological, or orthopedic condition
- Patient cannot walk 200 feet without stopping to rest because of one of the above five conditions
- Patient is missing a hand or arm, or has permanently lost the use of a hand or arm

**Length of Accommodation:** Provide a timeline for these restrictions,

modifications, or adjustments listed above:

Temporary. Provide the estimated end date for restrictions: \_\_\_\_\_

Permanent/expected to last longer than 6 months: Estimate end date: \_\_\_\_\_

Unknown. Please explain: \_\_\_\_\_

**Questions or Comments**

Questions or comments: \_\_\_\_\_

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**Section 3: Health Care Provider Information**

Health Care Provider Name and Area of Practice\* \_\_\_\_\_

Name of Company/Clinic\* \_\_\_\_\_ Office Phone\* \_\_\_\_\_

State Professional License Number\* \_\_\_\_\_ Office Fax \_\_\_\_\_

Provider Signature\* \_\_\_\_\_ Date\* \_\_\_\_\_

**\*Required Information**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.