UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

OFFICE FOR ACCESS & EQUITY
Accessibility and Accommodations Division
Fax: 217-244-9136

Parking Accommodation Medical Form

The Office for Access and Equity at the University of Illinois facilitates reasonable accommodations, including parking accommodations, for employees based on disability, as well as pregnancy, childbirth, and related medical conditions.

This form should be completed and signed by a treating health care provider who is familiar with employee's medical condition/diagnoses, the resulting impacts and limitations on the employee's life activities, and the expected duration of those limitations. Submission instructions can be found at the end of the form. In lieu of this form, the employee may submit medical documentation that provides the necessary information.

Part 1: Completed By Employee

Employee Name: _____ DOB: _____ Employee UIN: _____

Job Title:_____ Department: _____

Part 2: Completed by the Health Care Provider

Pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA), genetic information about the employee or their family members is not requested or required, including: family medical history, results of genetic tests, the fact that the employee or their family member sought or received genetic services, and genetic information of an embryo or fetus.

Employee's Diagnosis. Please identify the employee/patient's diagnosed medical condition(s) that warrant providing a parking accommodation:

_____

Check any/all of the following categories of medical/health conditions that apply to the employee/patient:

☐ Recovery from injury or surgery

☐ Respiratory

☐ Mobility

☐ Cardiovascular

☐ Other (please describe) _____

Duration of accommodations:

☐ **Temporary**: Provide the estimated end date: _____

☐ **Permanent/ongoing**: Limitations/restrictions are expected to continue long-term/indefinitely.

OPTIONAL: If you have any additional comments, please provide them here:

_____

_____

_____

Section 3: Health Care Provider Information and Signature

Health Care Provider Name and Area of Practice* _____

Name of Company/Clinic* _____ Office Phone* _____

State Professional License Number* _____ Office Fax _____

I certify that the information I have provided on this form reflects my professional opinion and judgment based on having personally diagnosed/examined/treated the named employee/patient.

Provider Signature*_____ Date*_____

*Required Information

How to submit this form:

Health Care Providers: Please fax this form and any accompanying documentation to our office at 217-244-9136.

Employees: If your health care provider returns this form to you, please upload it to your online case file by logging into illinois-accommodate.symplicity.com or contact us at the email or phone number below for help.

Any Questions? Please call us at 217-333-0885, option #1, or email accessibility@illinois.edu.