EQUITY, CIVIL RIGHTS & TITLE IX
DISABILITY EQUITY OFFICE
UNIVERSITY OF MICHIGAN

Parking Accommodation Medical Form

The Disability Equity Office is requesting your assistance in facilitating a parking accommodation for a University of Michigan requestor who is seeking accommodation per the Americans with Disabilities Act Amendment Act (ADAAA). When completed by a current treating healthcare provider, this form is used to verify the requestor qualifies as a person with a disability and helps the Disability Equity Office determine how to best accommodate the requestor. If you have any questions, please contact 734-763-0235.

Section 1: Completed by Requestor

Requestor Name:_____DOB:_____

U-M Uniqname:_____Email:_____

Job Title:_____Department: _____

Section 2: Completed by Health Care Provider

Requestor's Diagnosis

Please identify the diagnosis(es) for the above-named requestor:

_____

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

☐ Individual has Blindness. Describe corrected acuity level (right eye; left eye, both eyes, & visual field in degrees):_____

☐ Individual has an inability to walk more than **200 feet** without having to stop and rest.

☐ Individual must use a wheelchair, walker, crutch, brace, or other ambulatory aid to walk. Describe:_____

☐ Individual has a lung disease from which the forced expiratory volume for one second, when measured by spirometry, is less than one liter, or from which the arterial oxygen tension is less than 60mm/hg of room air at rest.

☐ Individual has a cardiovascular condition which measures between 3 and 4 on the New York Heart Classification Scale, or which renders the patient incapable of meeting a minimum standard for cardiovascular health established by the American Heart Association and approved by the Michigan Department of Health and Human Services.

☐ Individual has an arthritic, neurological, or orthopedic condition that severely limits ability to walk. Describe:_____

☐ Individual has persistent reliance upon an oxygen source other than ordinary air.

Length of Disability

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

_____

_____

Section 3: Health Care Provider Information

Healthcare Provider Name and Area of Practice:_____

Name of Company/Clinic:_____

Office Phone:_____State Professional License Number:_____

Provider Signature:_____Date:_____

Providers: Please submit this form by email to: DisabilityEquity@umich.edu.
Employees: Please upload the completed document into your Accommodate case file at https://ecrt-umich-accommodate.symplicity.com/.

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.