EMPLOYEE REQUEST FOR PARKING AS A REASONABLE ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT

Part 1 EMPLOYEE INFORMATION **(Please print and sign)**

Name: _____ Telephone No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

_____ _____

Employee Signature Date

Part 2 MEDICAL CERTIFICATION – **This section must be completed by the appropriate health care or rehabilitation professional, depending on the specific disability. The above-named employee has informed the Rochester City School District that he/she has a disability that necessitates special parking as an accommodation under the American with Disability Act. A "disability" for this purpose means a physical or mental impairment that substantially limits the employee's ability to walk to and from the employee parking lot.**

Please check either Temporary or Permanent Disability:

☐ **TEMPORARY DISABILITY: six months or less**

Diagnosis: _____

Expected recovery date: _____

Does this disability *substantially limit* the patient's ability to walk?

200 ft? Y / N 400 ft? Y / N 800 ft? Y / N

Please explain: _____

_____

☐ **PERMANENT DISABILITY: six months or more**

6 months to 1 year? Y / N more than 1 year? Y / N

Diagnosis: _____

Expected recovery date: _____

Does this disability *substantially limit* the patient's ability to walk?

200 ft? Y / N 400 ft? Y / N 800 ft? Y / N

Please explain: _____

_____

Part 3 HEALTH CARE PROVIDER'S INFORMATION

Name: _____ Title: _____

Address: _____ Telephone No.: _____

By signing this document, I hereby certify that I am the appropriate health care provider, and that the medical information I am providing is true and complete.

_____ _____

Signature Date