Duke | Employee Occupational Health and Wellness

Special Parking* Request Form

Sections A & B to be completed by Employee

Section A:

Date: _____ **DUID#:** _____

Name: _____

Primary Work Location: _____ **Current Parking Location:** _____

Home Phone: _____ **Email:** _____

Office Phone: _____ **Email:** _____

Department: _____ **Supervisor/Manager:** _____

Phone: _____ **Email:** _____

** Please note that mobility limitations will apply to work duties, if pertinent.*

I. Nature of Health Problem and Reason(s) for Special Parking:

_____

_____

II. Release of Medical Information:

I, _____, voluntarily give Duke University EOHW permission to obtain information from Dr(s). _____ Address at _____ (phone number) and/or review my electronic records at Duke University Health System, as necessary, to obtain further health information related to my request for special parking consideration. I further understand that all information obtained will be maintained and used in accordance with applicable confidentiality requirements.

Signature: _____ **Date:** _____

Completed form Sections A, B & C must be forwarded to Employee Occupational Health and Wellness (EOHW), Box 3148, DUMC, Durham, NC 27710, (Fax) 919-681-0538.

EOHW will remove personal health information and make recommendations to the Parking Office and advise you of the completed review by email. **Contact Parking Office at 919-684-5049 after EOHW has notified you.**

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Documentation from your Treating Health Care Professional for Special Parking Consideration

Section B:

Date: _____ **Name:** _____

Med. Record #: _____ **Date of Birth:** _____

Release of Medical Information:

I, _____, voluntarily give Duke University Health System and/or Dr(s). _____ Address _____, permission to share medical information as necessary with Duke EOHW, for discussion/evaluation as it relates to my request for special parking. **Signature:** _____ **Date:** _____

Information in this section must be completed by **Treating Health Care Professional**

Section C:

Date: _____

A. Brief Description of Condition with Diagnosis and Medically Necessary Limitation of Activity:

_____

_____

B. Is the condition: ☐ Temporary Duration: _____ ☐ Permanent

C. Maximum walking distance (in feet): _____

(city block = 200-400 feet, basketball court length = 94 feet, average car length = 14-15 feet)

***** PLEASE BE AWARE OF POSSIBLE IMPACT OF THIS LIMITATION ON ABILITY TO PERFORM JOB DUTIES.

D. Is the employee able to negotiate stairs? ☐ No ☐ Yes

Maximum Capacity of Stairs? ☐ 1-4 ☐ 5-10 ☐ Greater than 10

E. Requires Mobility Assistive Device? ☐ No ☐ Yes

(cane, walker, scooter, etc.)

I ATTEST THAT THE INFORMATION ABOVE REPRESENTS MY OPINION SUPPORTED BY CLINICAL DOCUMENTATION IN THE MEDICAL RECORD AND EXAMINATION OF MY PATIENT.

Signature of Provider: _____ **Printed Name or Stamp:** _____

Address: _____ **Phone:** _____