

WAU Staff Special Access Parking Verification Form

For Academic Year: 20__ - 20__

Section I – (Employee completes)

Employee Name: _____

WAU Employee ID: _____

Department: _____

Section II (Physician or other Medical Professional)

Based on my best medical judgement, the above named employee needs an accommodation with his/her parking location to minimize the distance between the parking venue and the employee's normal office location.

Duration of Accommodation

___ Temporary: From _____ to _____

___ Indefinite (*Valid for current academic year only*)

Signature of medical professional

Date