# Attending Physician's Statement
## (Request for proximity parking permit or adapted transport)

_____ _____
Employee's name McGill ID #

I authorize the release of any information with respect to this claim to my employer and/or his representative.

_____ _____
Employee's signature Date

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**To the Employee:**

Please indicate the name of the building you are working in: _____

Please indicate if this request is for proximity parking and/or adapted transport? Proximity Parking ☐ Adapted transport ☐

Do you have a certificate for parking for persons with a disability from the SAAQ? ☐Yes ☐No

If yes, submit this part of form with a copy your certificate for parking from the SAAQ directly to parking.services@mcgill.ca

If no, please submit this form with information provided by your attending physician to disability.hr@mcgill.ca

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**To the Attending Physician,**

McGill University wishes to accommodate its employees whose medical condition limits their ability to walk about on campus or take public transportation to and from the campus. We provide access via adapted transport on campus and/or parking on campus. Since access to these services is limited and to determine if your patient is eligible for the services, we need you to provide all the information requested below.

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**Diagnosis:** _____

**Treatment Plan**:_____

Please indicate the medical restrictions preventing your patient from walking on campus and/or taking public transportation, the degree of severity and details of the restrictions.

| **Restrictions** (e.g. limited ability to walk, stand, etc.) | **Degree of severity:** Light, Moderate, Severe | **Details of restrictions** (e.g. maximum distance the patient can walk, maximum time the patient can stand, etc.) |
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**Other comments:**

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**Duration of the restrictions**: _____

Are you recommending that your patient apply to obtain a certificate for parking for persons with a disability from the SAAQ? Yes ☐ No ☐

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***PHYSICIAN INFORMATION***

Name_____ Licence #_____

Signature _____Date _____

Address, phone #, and fax #, or clinic stamp

***The employee is responsible for the completion of this form without expense to the University.*** *(2019)*