Human Resources

Medical Statement by a Health Care Provider

For a temporary parking accommodation request

Date: _____ Employee Name: _____

Employee Email: _____

Dear Health Care Provider:

We are requesting medical documentation to substantiate the above named employee's request for a temporary parking accommodation on MIT's campus. A temporary parking accommodation may enable the above employee to park closer to their work space on campus than where they normally park.

Please complete this form and then either you or the employee may return it to MIT's Disabilities Services and Medical Leaves Office (DSMLO) via secure email or FAX.

1. Does the employee have a medical impairment that limits them from long-distance walking? ☐ Yes ☐ No
2. What is the impairment, including the patient's functional limitation, diagnosis and prognosis? _____
   _____
   _____
3. When was the employee last seen by you for this impairment? _____
4. MIT typically offers temporary parking accommodations for a period of up to six weeks.How long do you anticipate this individual will need this parking accommodation?
   _____ weeks

As the employee's request for a parking accommodation is being evaluated, we may need to ask for more detailed information. Thank you for your assistance.

Employee signature: _____ Date: _____

Provider signature: _____ Date: _____

Provider name and title (print): _____

Provider address: _____

Provider phone number: _____

MIT Disabilities Services and Medical Leaves Office

77 Massachusetts Ave.
Building NE49-5000
Cambridge, MA 02139
Phone: 617-253-9496
Email: hr-dsmlo@mit.edu

Return form:
Secure FAX: 617-253-1502
Secure email: https://mit.dropsecure.com/send/dsmlo