YALE UNIVERSITY
Employee Request Application for Parking Privileges

This Section to be filled out by the Employee:

Employee’s Name: ________________________________
Employee’s Signature: ________________________________
Campus Address: ________________________________
Phone Number(s): (Home) ___________________ (Work) ___________________ (Cell) ___________________
Email Address (if available): ________________________________

Is this a new request or an extension? Circle one: new extension

This Section to be filled out by Health Care Provider:

1. Is this a permanent disability? Yes ________ No _______

2. If no, how many days, weeks, or months will the parking privilege be needed for: ______________________

3. Does the employee hold a State of Connecticut handicapped permit: Yes ________ No _______
   If yes, Permit #: ________________________________

4. Number of city blocks the employee can walk: ________________________________

5. Please attach documentation or provide a brief description below of the medical condition which necessitates
   the use of the special van transportation. (Medical details will be treated as confidential information)
   ________________________________________________________________________________________
   ________________________________________________________________________________________

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by
GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as
specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this
request for medical information. “Genetic information,” as defined by GINA, includes an individual's family medical history, the
results of an individual's or family member's genetic tests, the fact that an individual or any individual's family member sought or
received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an
embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of employee’s health care provider (please print): ________________________________
Signature of employee’s health care provider: ________________________________
Date: ________________________________

This request will be reviewed by the Office for Equal Opportunity Programs (OEOP).

Please return completed form to:
Office for Equal Opportunity Programs
221 Whitney Avenue, P.O. Box 208295, New Haven, CT 06520-8295
Phone: (203) 432-0849, Fax: (203) 432-7884

Office Use Only
Approved _______ Rejected _______
Signature: ________________________________ Date: ________________________________
rev 02/11