EMPLOYEE REQUEST FOR TEMPORARY DISABLED PARKING ASSIGNMENT

(TEMPORARY PARKING IS 3 MONTHS OR LESS)

Before completing this form, refer to MATC procedure GG105 for details and requirements

Please print:

Section I. Employee Information (Complete only section I)

Cosmo ID: _____

Last name: _____First name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip code: _____

Contact telephone number(S): _____

Name of parking facility requested:_____

WI Department Transportation Disabled Permit Number or Disabled Vehicle License No. : _____

Reason for Request: _____

(Supporting medical documentation must accompany this form at the time it is submitted for consideration.)

I, _____, authorize _____ to
(Healthcare provider)
release documentation to Human Resources at Milwaukee Area Technical College, **relating to the medical need for temporary parking accommodations and in particular, my ability to walk a distance of two blocks**.

Signature _____ Date _____

Section II. Decision (Human Resources section only)

Temporary Disabled Parking Assignment **is** approved as submitted: _____ Date: _____
Signature of Parking Representative (Employee Wellness & Risk Coordinator

The Request for Temporary Disabled Parking Assignment **is** NOT approved as submitted: _____Date: _____

Signature of Parking Representative (Employee Wellness & Risk Coordinator

Comments: _____
