

PHYSICIAN'S VERIFICATION FORM – BUILDING 7 ELEVATOR

Confidential
Rec'd ___/___/___ Comp Req Rep
Thru: Fall Spring Sum ___/200___

Please print clearly. Incomplete forms will not be processed.

Return to Student ACCESS Office, 874 Dillingham Blvd. (5-107B), Hon., HI 96817 or FAX 808-844-2391. Banner I.D. # or Birthdate

Last Name First Name M.I.
Mailing Address City HI Zip Code
Phone (please circle: home/work/cell) Email address @

Students: Submit to Student ACCESS this completed form or provide a photocopy of your State of Hawai'i Disability Parking Placard I.D. card to request floor-to-floor elevator access to get to your classes. All students requesting this accommodation should inform Student ACCESS of their abilities to get to and from class when this floor-to-floor elevator is out-of-service or in the event of an emergency. For questions, please call 844-2392 (voice/text).

Physicians: Please complete all sections below with your signature and official stamp. Thank you!

ELEVATOR REQUEST:

My patient's condition is

Please mark reason and elaborate:

- Inability to walk up and/or down the stairs.
Other reason:

Accommodation should be for: ___ week's ___ this semester only ___ this academic year.

If the floor-to-floor elevator becomes inoperable up to 3 days (short term), my patient:

- Can walk up or down a half flight of stairs to get to/from class.
Cannot walk up or down a half flight of stairs to get to/from class.
Relocate class Yes or No
Impact if unable to relocate class:

If the floor-to-floor elevator becomes inoperable for more than 3 days (long term), my patient:

- Can walk up or down a half flight of stairs to get to/from class.
Cannot walk up or down a half flight of stairs to get to/from class.
Relocate class Yes or No
Impact if unable to relocate class:

In an emergency, in order to exit the building, my patient:

- Can walk down the stairs & does not require help.
Can walk down the stairs but requires help.
Cannot walk down the stairs and would need evacuation assistance.

EXAMINING PHYSICIAN TO SIGN

As M.D., I attest the above to be true.

Physician's Signature Date Phone # Official Stamp

Printed Name Address